



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

TEXAS BONE AND JOINT CENTER

**Respondent Name**

STATE OFFICE OF RISK MANAGEMENT

**MFDR Tracking Number**

M4-16-0943-01

**Carrier's Austin Representative**

Box Number 45

**MFDR Date Received**

December 11, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Please note, the above claim was denied due to an error. Please accept this as our formal appeal in order to reconcile the error

Your carrier has denied this claim for several reasons. The first reason is that this is a repeat procedure of lab testing. It is not. Please give specific date of last drug test to verify this claim. The second reason for denial is required or inconsistent modifier with procedure. This is another fact that is not true. We bill per guidelines. SORM is the **ONLY** Company that does not pay for this service, so does Travelers have their own set of guidelines that other carriers do not? Therefore, we would like a specific breakdown on the modifiers that are not correct or incorrectly used. And as far as the denial for the place of service if you would please reference the place of service on this claim, again, you are wrong. The place of service is laboratory, not office."

**Amount in Dispute:** \$4,048.70

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "This will acknowledge receipt of the Request for Medical Dispute Resolution on the above referenced claim by the State Office of Risk Management (Office). Upon notification o this dispute the Office performed a review of the dispute packet received from Texas Bone & Joint Center. The Office found that the requestor waived their right to dispute the denial of additional reimbursement as the medical fee dispute was not timely filed to TDI-DWC within the one year from date of service pursuant to §Rule 133.307(c) (1). The Office respectfully requests the Division to dismiss this dispute in accordance with Rule 133.307(f) (3) (D)."

**Response Submitted by:** State Office of Risk Management 300 W 15<sup>th</sup> Austin TX 78701

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 15, 2014	CPT Code 82542, 82649, 82646, 82742, 83925, 80160, 80152, 80154, 83805, 80174, 83840, 82145, 83992, 82520, 80184, 82205 and 80104	\$4,048.70	\$0.00

## **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - W3 – Additional payment made on appeal/reconsideration
  - 193 – Original payment decision is being maintained. This claim was processed properly the first time
  - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted

### **Issues**

1. Did the requestor waive the right to medical fee dispute resolution?

### **Findings**

1. 28 Texas Administrative Code §133.307(c)(1) states:

Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

(A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

The date of the services in dispute is August 15, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on December 11, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

## **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

Signature	Medical Fee Dispute Resolution Officer	12/18/15 Date
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## ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**