



TEXAS DEPARTMENT OF INSURANCE

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

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

CONSULTANTS IN PAIN MEDICINE

Respondent Name

TEXAS MUNICIPAL LEAGUE INTERGOVERNMENTAL RISK

MFDR Tracking Number

M4-16-1246-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We content that Texas Municipal League did not apply the 28 Texas Administrative Code Rules and Guidelines when auditing the laboratory services. All the Texas Municipal League denials cite the documentation submitted does not support the services and claim lacks information or has submission/billing error which is needed for adjudication, no fee due under contract because services exceed treatment guidelines (OGD) adopted by network, charges exceed fee schedule maximum allowable and benefits for this service included in allowance for another service."

Amount in Dispute: \$88.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The disputed service date is December 22, 2014. Requestor's DWC-60 is stamped as received by the Division on January 22, 2016. A provider must request medical dispute resolution on a fee issue or a retrospective medical necessity review within one year of the date of service ... A decision should be issued that this request is untimely and the Division has no jurisdiction for further review."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 22, 2014	CPT Code 80152, 80182, 82542, 82570 and 83986	\$88.91	\$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:

- P12 – Workers compensation jurisdictional fe
- 150 – Payment adjusted because the payer deem
- 45 – Charge exceeds fee schedule/maximum all
- 50 – These are non-covered services because
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
- W3 – Additional payment made on appeal/reconsideration documentation does not support need for intensive testing

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 December 22, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on January 11, 2016. 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

2/11/2016
Date

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.