



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

METROPOLITAN ANESTHESIA CONSULTANT

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-16-2847-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

MAY 17, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Claim was billed to insurance as soon as workers comp insurance was obtained."

Amount in Dispute: \$2,261.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "One year from disputed date 6/7/13 is 6/7/14. The TDI/DWC date stamp lists the received date as 5/17/16 on the requestor's DWC-60 packet, a date greater than one year from 6.7.13. The requestor has waived its right to DWC MDR. No payment is due."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: June 7, 2013, CPT Code 15940, \$2,261.00, \$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 requestor did not submit any explanation of benefits for CPT code 15940. The submitted bill and explanation of benefits lists code 00300 as the service rendered on June 7, 2013 for \$2,261.00. CPT code 00300 was reduced/denied by the respondent with the following reason codes:
- CAC-29-The time limit for filing has expired.
- 731-Per 133.20(B) provider shall not submit a medical bill later than the 95th day after the date the service.
- 891-No additional payment after reconsideration.
- CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193-Original payment decision is being maintained, upon review it was determined that this claim was processed properly.

- CAC-18-Exact duplicate claim/service.
- 878-Appeal (Request for Reconsideration) previously processed, refer to rule 133.250(H).
- 879-Rule 133.250(B)-Health care provider shall submit the request for reconsideration no later than 10 months from the date of service.
- CAC-138-Appeal procedures not followed or time limits not met.

**Issue**

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

**Findings**

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 service in dispute is June 7, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on May 17, 2016. This date is later than one year after the date 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 reimbursement is due.

**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 services in dispute.

**Authorized Signature**

Signature	Medical Fee Dispute Resolution Officer	6/9/2016 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 MDR 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.**