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
Gregory Ennis, MD

Respondent Name
Texas Mutual Insurance

MFDR Tracking Number
M4-16-3143-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 14, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review the entire narrative report to find the elements required for ROS, PFSH and HPI. In addition please review the exam score sheet attached demonstrating that an exam was performed meeting the level of service billed herein. This of course would meet the requirements of two of three components of documentation required for subsequent visits."

Amount in Dispute: $185.96

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester billed code 99214. Texas Mutual denied payment because the requestor's documentation does not meet the CPT criteria for 99214. The History is expanded problem focused, the Examination is expanded problem focused, and the Medical Decision making is straightforward. Texas Mutual declined to issue payment for the DWC73 as there was no change in work status from the previous DWC73."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 11, 2015	99214, 99080 -73	$185.96	$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 fee schedule adjustment
- 150- Payer deems the information submitted does not support this level of service
- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
- 225 – The submitted documentation does not support the services being billed. We will re-evaluate this upon receipt of clarifying information
- 248 – DWC-73 in excess of the filing requirements; no change in work status and/or restrictions; reimbursement denied per Rule 129.5
- 890 – Denied per AMA CPT description for level of service and/or nature of presenting problems

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 June 11, 2015. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on June 14, 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

		August , 2016
Signature	Medical Fee Dispute Resolution Officer	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.