TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Wright W. Singleton, M.D.

**Respondent Name**
Texas Mutual Insurance Company

**MFDR Tracking Number**
M4-18-0814-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
November 27, 2017

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "I tried to solve this issue for nearly a year through Coventry…"

**Amount in Dispute:** $650.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "One year from disputed date 7/22/16 is 7/22/17. The TDI/DWC date stamp lists the received date as 11/27/17 on the requestor's DWC-60 packet, a date greater than one year from 7/22/16. The requestor has waived its right to DWC MDR. No payment is due."

**Response Submitted by:** Texas Mutual Insurance Company

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 22, 2016 | Required Medical Examination | $650.00 | $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:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 724 – No additional payment after a reconsideration of services.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

**Issues**

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 the services in dispute is July 22, 2016. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on November 27, 2017. 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 additional reimbursement is due. As a result, the amount ordered is $0.00.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

| | Laurie Garnes | June 22, 2018 |
|---|---|---|
| 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 Rule §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. **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**.