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
DALLAS MEDICAL MULTICARE

Respondent Name
INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number
M4-18-2620-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 19, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our reason to request payment for the denied services:

The approval letter provided by the insurance carrier does not support that the approval included a discussion to limit the number of units being authorized. For this reason, the insurance carrier's denial reason is not supported for CPT 97140."

Amount in Dispute: $ 503.82

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "THIS REQUEST FOR MEDICAL FEE DISPUTE RESOLUTION SHOULD BE DISMISSED AS THE PROVIDER FAILED TO TIMELY FILE THE REQUEST WITHIN ONE YEAR OF THE DATES OF SERVICE AS REQUIRED BY RULE 133.307(c)(1) … The Provider alleges they are entitled to reimbursement for the disputed services. The Provider has waived the right to reimbursement under Rule 133.307 as they did not timely file their Request for Medical Fee Dispute Resolution with the Division within one year of the date service as required by Rule 133.307(c)(1)."

Response Submitted by: Constitution State Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 05, 2016	Code 97140	$503.82	$0.00
May 18, 2016			
May 19, 2016			
May 24, 2016			
May 31, 2016			

June 01, 2016			

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:
    - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment
    - 247 – A payment or denial has already been recommended for this service
    - 18 – Previously paid. Payment for this claim/service may have been provided in a previous payment
    - 119 – Benefit maximum for this time period or occurrence has been reached
    - 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services

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 May 05, 2016 to June 01, 2016. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on March 19, 2018. 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

		April 19, 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 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.