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
Burke Douglas DC

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-18-4347-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is an appeal letter for a denial of services. The patient was seen by multiple Doctor. Dr. Burke Treating Doctor Tax ID # 27-2269586 for musculoskeletal system and Dr. Francis Burch, MD for medication management Tax ID # 74-2056211."

Amount in Dispute: $2,015.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider filed a DWC-60 requesting Medical Fee Dispute Resolution for services between March 8, 2016 and September 27, 2016. The provider filed his DWC-60 on July 17, 2018 … The provider's DWC-60 was not timely filed pursuant to Division Rule 133.307(c)(1)(B)(i)."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 17, 2016	Code 99123	$2,015.00	$0.00
March 8, 2016	Code 97140		
March 10, 2016	Code 97110		
March 15, 2016	Code 97110 and 97140		
March 29, 2016	Code 97110 and 97140		
April 12, 2016	Code 99213		
April 19, 2016	Code 97110 and 97140		

April 20, 2016	Code 97110 and 97140		
July 13, 2016	Code 99213		
August 10, 2016	Code 99213		
September 06, 2016	Code 99213		
September 19, 2016	Code 99213		
September 27, 2016	Code 99213		

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:
    - 39 – Services denied at the time authorization/pre-certification was requested
    - P6 – Based on entitlement to benefits
    - 16 – Claim/service lacks information or has submission/billing error(s)
    - 193 – Original payment decision is being maintained upon review, it was determined that this claim was processed properly
    - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
    - 219 – Based on extent of injury
    - 18 – Exact duplicate claim/service

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 February 17, 2016 to September 27, 2016. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on July 17, 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

		9/7/2018
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.