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
Clinics of North Texas

Respondent Name
Wichita Falls ISD

MFDR Tracking Number
M4-19-0132-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
September 11, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This letter is written as a request for a medical fee dispute resolution. We have mailed a reconsideration to Claims Administrative Services and it was denied. The original claim was denied for Extent of Injury."

Amount in Dispute: $159.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The charge in question was initially received on 2/27/17, and on 3/17/17 it was denied based on extent. On 12/27/17 we received a reconsideration and on 1/2/18, the denial was maintained. In addition, the reconsideration was found to be pas timely filing of a reconsideration. A copy of both bill and EOB's are attached."

Response Submitted by: Claims Administrative Services Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 20, 2017	Code 99213	$159.00	$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 §133.305 sets out the procedure for Medical Fee Dispute Resolution.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - 219 -Based on Extent of Injury

- 722 – The extent of injury has been disputed, this treatment is unrelated to the compensable workers compensation injury

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. Does the medical fee dispute referenced above contain information/documentation to support that date(s) of service February 20, 2017 contains unresolved issues of Compensability, Extent-of-Injury and/or Liability?

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.

   The date of the services in dispute is February 20, 2017. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on September 11, 2018. This date is later than one year after the date(s) of service in dispute. 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.

2. The requestor seeks resolution for Code 99213 rendered on February 20, 2017. Review of the submitted documentation finds that the medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

   28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services.

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

		10/11/2018
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.