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
John R Reneau

Respondent Name
City of Wichita Falls

MFDR Tracking Number
M4-19-0354-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 21, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Requestor did not provide a position statement.

Amount in Dispute: $3,232.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please note that the TDI-DWC date stamp for this MFDR request is 9/21/2018, the dates of service are 1/29/2016- 5/2/2016 which exceeds the one year filing deadline as outlined in rule 133.307(c)(1)(B)."

Response Submitted by: STARR COMPREHENSIVE SOLUTIONS INC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 29, 2016 to May 22, 2016	Codes 97110, 97140, G0283, 97140, 97002, G8990 and G8991	$3,232.00	$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:
    - 29 – The time limit for filing has expired
    - W3 – Additional reimbursement made on reconsideration
    - 198 – Payment denied/reduced for exceeded precertification/authorization
    - 193 – Original payment decision is being maintained. This claim was processed properly the first time

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 246 – This non-payable code is for required reporting only
- 228 – Penalty or Interest Payment by Payer
- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service
- 219 – Based on extent of injury
- 246 – This non-payable code is for required reporting only

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.

   The date of the services in dispute is January 29, 2016 to May 22, 2016. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on September 21, 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

		11/2/2018
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.