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
Francisco J Battle MD

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-19-0890-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement provided.

Amount in Dispute: $325.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor did not provide evidence of the date of its receipt of the CCH decision. Further, Texas Mutual denied payment of the requestor's bill based on the PLN-11 of 4/6/17 disputing in part involvement of the cervical region to the compensable injury … One year from disputed date 2/15/17 is 2/15/18. The TDI/DWC date stamp lists the received date as 10/16/18 on the requestor's DWC-60 packet, a date greater than one year from 2/15/17.."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 15, 2017	Code 99203	$325.00	$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-219 – Based on extent of injury
    - 246 – The treatment/service has been determined to be unrelated to the extent of injury. Final adjudication has not taken place

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. Is the denial of extent of injury supported?

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 15, 2017. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on October 16, 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 service in dispute was denied by the workers' compensation carrier due to an unresolved extent of injury issue. The extent of injury denial was timely presented to the requestor in the manner required by 28 Texas Administrative Code §133.240.

   Documentation provided included a Division-Contested Case Hearing between the injured employee and the carrier which identified the accepted injury, and also identified those conditions that were excluded.

   Whether the health care provider treated the conditions accepted under that decision and order, or whether the health care provider treated conditions that were excluded under the decision and order is not a question that can be addressed through the medical fee dispute process. Specifically, 28 Texas Administrative Code §133.305(b) states that an extent of injury shall be resolved prior to the submission of a medical fee dispute.

   Because the service in dispute contains unresolved extent issues, this matter is not ripe for adjudication of a medical fee under 28 Texas Administrative Code §133.307.

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

		11/28/2018
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.