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
Dr. Christopher Henn

Respondent Name
Hartford Fire Insurance Co

MFDR Tracking Number
M4-19-1618-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
November 19, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement submitted by the health care provider.

Amount in Dispute: $6,720.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "All of the service dates between October 21, 2016 and November 9, 2017 should be dismissed on the basis that the DWC-60 was not filed within one year of each of those dates of service. Additionally, the October 15th, October 19th and October 26, 2018 dates of service could not have progressed to the point of the provider exhausting its remedies prior to filing the DWC-60. As a consequence, they should be dismissed as well. Moreover, all dates of service for which the provider cannot prove that he submitted a CMS-1500, should also be dismissed. The carrier is specifically addressing the dates of service of March 10th, April 24th, June 12th and July 13, 2017."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 21, 2016 through October 26, 2018	Professional medical services	$6,720.00	$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. 28 Texas Administrative Code §133.20 sets out the requirements for submission of medical bills.
3. 28 Texas Administrative Code §133.250 sets out the guidelines for reconsideration of medical bills.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired
   - 937 – Services(s) are denied based on HB7 provider timely filing requirement
   - 5566 – The time limit for filing has expired
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 309 – The charge for this procedure exceeds the fee schedule adjustment
   - 906 – In accordance with clinical based coding edits (National Correct coding initiative/outpatient code editor), component code of comprehensive medicine, evaluation and management services procedure (9000-99999) has been disallowed
   - 5584 – Preauthorization required but not requested
   - 18 – 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
   - 4271 – Per Tx Labor Code Sec 413.016, providers must submit bills to payors within 95 days of the date of service.

Issues

1. Was the health care provider's request for MFDR timely?
2. Is the insurance carrier's position statement supported?

Findings

1. The health care provider is seeking reimbursement of $6,720.00 for professional services rendered from October 21, 2016 through October 26, 2018.

   The request for MFDR was received on November 19, 2018. 28 TAC 133.307 (c) (1) (A) states,

   > Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division.
   >
   > (1) 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 health care provider did not submit a position statement to support an exception of related compensability, extent of injury, liability, medical necessity or a refund notice is applicable to this dispute.

   The health care provider has waived the right to medical fee dispute for the dates of service October 21, 2016 through November 9, 2017.

2. The respondent states in their position statement, "…before a provider is allowed to file a DWC-60, request for Medical Fee Dispute Resolution, the provider must have first submitted an initial bill to the carrier, submitted a request for reconsideration to the carrier and allowed the carrier to respond to the request for reconsideration."

   28 TAC 133.250 (i) states,

   > If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

Reconsideration is therefore required prior to filing for medical fee dispute. The health care provider did not request reconsideration before this medical fee dispute was filed. For that reason, dates of service January 15, 2018 through October 26, 2018 are dismissed pursuant to Rule 133.307(f)(3)(A)

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. The amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Peggy Miller	December , 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 Rule §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. **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.