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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
RODNEY CALDWELL, MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-19-1904-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
DECEMBER 3, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "we are submitting this dispute and all accompanying documents needed to amend this and therefore receive the remaining pending amount of $650.oo for the services rendered to [Claimant], as commissioner ordered, on 10/05/2017."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "One year from disputed date 10/5/17 is 10/5/18. The TDI/DWC date stamp lists the received date as 12/3/18 on the requestor's DWC-60 packet., a date greater than one year from 10/5/17"

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2017	CPT Codes 99456-W5-WP, 99456-W6-RE, 99456-W7-RE and 99456-W8-RE	$650.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 services in dispute were reduced / denied by the respondent with the following reason code:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-138-Appeal procedures not followed or time limits not met.
   - 724-No additional payment after a reconsideration of services.
   - 790-This charge was reimbursed in accordance to the Texas medical fee guidelines.
   - 879-Rule 133.250(B)-Health care provider shall submit the request fore reconsideration no later

than 10 months from the date of service.

- CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issue

Did the requestor waive the right to medical fee dispute resolution?

Findings

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 service in dispute is October 5, 2017. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on December 3, 2018. 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 for these services.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute for those dates have not been addressed.

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 services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	1/4/2019 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 MDR 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.