TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

Requestor Name
SCENIC MOUNTAIN MEDICAL CENTER

Respondent Name
TEXAS COTTON GINNERS TRUST

MFDR Tracking Number
M4-19-2045-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
December 10, 2018

## *REQUESTOR'S POSITION SUMMARY*

Requestor's Position Summary: The requestor did not submit a position statement for review.

Amount in Dispute: $73.25

## *RESPONDENT'S POSITION SUMMARY*

Respondent's Position Summary: "No further payment is due as prior recommending TX-FS was applied correctly..."

Response Submitted by: TCGT Agency, Inc.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Dispute Amount | Amount Due |
|---|---|---|---|
| October 9, 2017 to October 30, 2017 | Outpatient Hospital Physical Therapy Services | $73.25 | $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:
   - 59 – PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES.
   - 96 – NON-COVERED CHARGE(S).
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
   - P14 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS BEEN PERFORMED ON THE SAME DAY.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
   - 16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. REMARKS CODES WHENEVER APPROPRIATE.

**Issue**

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

**Findings**

28 Texas Administrative Code §133.307(c)(1) requires that a requestor shall timely file the request with the division's MFDR Section or waive the right to medical fee dispute resolution (MFDR).

Rule §133.307(c)(1)(A) further requires that a request for MFDR that does not meet any exceptions listed in Rule §133.307(c)(1)(B) be filed no later than one year after the dates of service in dispute.

The disputed dates of service extend from October 9, 2017 to October 30, 2017.

The request was received in the division's MFDR Section December 10, 2018.

This date is later than one year after the disputed dates of services.

Review of the submitted information finds the services do not involve issues identified in Rule §133.307(c)(1)(B). The division concludes the requestor 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 on the information submitted by the parties, in accordance with the provisions of Texas Labor Code §413.031, the division determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

| | Grayson Richardson | January 11, 2019 |
|---|---|---|
| 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.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.