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
CLINICS OF NORTH TEXAS, LLP

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-2157-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original claim was denied this provider has already billed and been reimbursed for an initial office visit… The patient saw 2 different doctors with 2 different specialties."

Amount in Dispute: $234.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CLINICS OF N TEXAS are participants in the Texas Star Network."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 20, 2017	Evaluation and Management Services	$234.00	$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:
   - A15 – THE REIMBURSEMENT FOR HEALTH CARE SERVICES ARE SUBJECT TO TEXAS STAR NETWORK CONTRACTS, A CERTIFIED WC HCN (INS CODE CH. 1305)
   - B16 – 'NEW PATIENT' QUALIFICATIONS WERE NOT MET
   - 138 – APPEAL PROCEDURES NOT FOLLOWED OR TIME LIMITS NOT MET.
   - 459 – THIS PROVIDER HAS ALREADY BILLED AND BEEN REIMBURSED FOR AN INITIAL OFFICE VISIT.
   - 879 – RULE 133.250(B) - HEALTH CARE PROVIDER SHALL SUBMIT THE REQUEST FOR RECONSIDERATION NO LATER THAN 10 MONTHS FROM THE DATE OF SERVICE.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.

- 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED LEGISLATED FEE ARRANGEMENT.
- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

Issues

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 date of service is March 20, 2017.

The request was received in the division's MFDR Section on December 17, 2018.

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

Review of the submitted information finds the services do not involve issues identified in Rule §133.307(c)(1)(B); consequently, the division finds the requestor failed to timely request medical fee dispute resolution.

The division concludes the requestor has waived the right to medical fee dispute resolution for these services.

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.