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
ELITE HEALTHCARE FORT WORTH

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-19-4468-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 11, 2019

Response Submitted By
No response received

REQUESTOR'S POSITION SUMMARY

"THIS IS AN INCORRECT DENIAL FROM THE CARRIER. CARRIER IS NOT PAYING ACCORDING TO AUTHORIZATION OUR FACILITY RECEIVED REGARDING THIS PATIENT."

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
March 28, 2018	Physical Therapy Services	$101.86	$0.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and 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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - V340 – CPT code submitted is based on service time and documentation of time spent does not support the number of units billed. Allowance has been reduced accordingly.
   - Z710 - The charge for this procedure exceeds the fee schedule allowance.
   - P300 – The amount paid reflects a fee schedule reduction.
   - 59 – Processed based on multiple or concurrent procedure rules.
   - W3 – Additional payment made on appeal/reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Findings

The Austin carrier representative for New Hampshire Insurance Company is Flahive, Odgen & Latson, Attorneys at Law, PC, who acknowledged receipt of a copy of the MFDR request on June 18, 2019. Pursuant to Rule §133.307(d)(1), if the division does not receive a response within 14 calendar days of dispute notification, the division may base its decision on the available information. To date, no response has been received. Consequently, this decision is based on the information available at the time of review.

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 28, 2018.

The request was received in the division's MFDR Section on June 11, 2019.

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

Review of the submitted information finds the circumstances do not involve any of the exceptions listed in Rule §133.307(c)(1)(B). Consequently, the MFDR request was not timely filed with the division.

The requestor has thus waived the right to MFDR for these services.

Conclusion

The requestor has waived the right to medical fee dispute resolution. Consequently, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	August 23, 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.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). The division must receive the request within twenty days of your receipt of this decision.

The request may be faxed, mailed or personally delivered either to the field office handling the claim or to the division at the contact information listed on the form. You must deliver a copy of the request to all other parties involved in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** together with any other information required by 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.