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
Zurich American Insurance Co

MFDR Tracking Number
M4-19-4658-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 25, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is not a duplicate claim/service. This is an incorrect denial from the carrier."

Amount in Dispute: $56.72

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The DOS was previously reviewed under topic 170832795. …It should also be noted that the MFDR numbers are different but they're for the same DOS."

Response Submitted by: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 15, 2019	97140	$56.72	$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 §134.203 sets out the reimbursement guidelines for professional medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 00104 – (39) Services denied at the tie authorization/pre-certification was requested
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Has the disputed service previously been considered at MFDR?

Findings

1. The requestor is seeking $56.72 for Code 97140 for date of service January 16, 2019.

   DWC finds the Code 97140 for date of service January 16, 2019 was part of dispute M4-19-4154-01. DWC reviewed the disputed services and issued a findings and decision on June 6, 2019.

   Because the requestor did not appeal the MFDR decision for HCPCS code 97140 issued on June 6, 2019 under docket number M4-19-4154-01, that decision is final per 28 TAC §133.307 (g). Therefore, DWC will not consider Code 97140 further.

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 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

		August 19, 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, 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.