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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
NeuroResorative

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-20-0200-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim has been billed as requested by TX Mutual with all the required documentation and are still being denied."

Amount in Dispute: $3,150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "One year from disputed date 6/30/2019. The TDI/DWC date stamp lists the received date as 9/23/19 on the requestor's DWC-60 packet, a date greater than one year from 6/30/18. The requestor has waived its right to DWC MDR."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 1 – 30, 2018	Rehabilitation Services	$3,150.00	$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:
   - 225 – The submitted documentation does not support the service being billed

Issue

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

Findings

28 Texas Administrative Code §133.307(c)(1) states a request for medical fee dispute resolution that does not involve issues of compensability, extent of injury or liability, medical necessity or a request for refund must be filed within one year from the date(s) of service.

The date of the service in dispute is June 1 – 30, 2018. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on September 23, 2019.

This date is later than one year after the date(s) of service in dispute. Review of the submitted explanation of benefits finds that the disputed services do not involve issues identified above.

The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute 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 disputed services.

Authorized Signature

______________________	______________________	October 31, 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 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.