



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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

RODNEY CHAN, MD

Respondent Name

SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number

M4-20-0425-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

OCTOBER 17, 2019

REQUESTOR'S POSITION SUMMARY

No position summary was submitted.

Amount in Dispute: \$11,035.36

RESPONDENT'S POSITION SUMMARY

"We are upholding the last reevaluation bill SLTX-96574. The bill was denied for the operative report and provider did not submit to carrier. Request for reconsideration was also received after the 10-month timely filing limit. Provider has submitted op report with MFDR but carrier never received."

Response Submitted by: AVIDEL

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 21, 2018	CPT Code 11043	\$849.60	\$0.00
	CPT Code 11046	\$547.00	\$0.00
	CPT Code 14301	\$4,198.92	\$0.00
	CPT Code 27070	\$3,333.56	\$0.00
	CPT Code 27060	\$1,830.52	\$0.00
	CPT Code 97606	\$203.76	\$0.00
TOTAL		\$11,035.36	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code §133.307 (TAC), effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 16- Claim/service lacks information or has submission/billing error(s).
 - 241-Not documented.
 - 282-The insurance company is reducing or denying for reconsideration or appeal.
 - 758-Bill was not submitted timely in accordance with DWC chapter 133.
 - P12-Workers’ compensation jurisdictional fee schedule adjustment.
 - 5793-Treatment provided was not based on the correct application of the guidelines.
 - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
 - 375-Received re-evaluation request with timely filing documentation. However previously denied due to operative report was not received. We are standing on prior review.
 - 375-A healthcare provider shall submit the request for reconsideration no later than 10 months from the date of service.

Issue

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

Findings

28 TAC §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the DWC's MFDR Section or waive the right to MFDR. The DWC shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of service in dispute is May 21, 2018. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on October 17, 2019. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The DWC concludes that the requestor has failed to timely file this dispute with the DWC's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these services.

Conclusion

The DWC finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 TAC §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute for those dates 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 DWC has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

10/31/2019

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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.