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
CAPITAL CITY ORTHOPAEDICS

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-20-0542-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
OCTOBER 24, 2019

REQUESTOR'S POSITION SUMMARY

"Screen shot below shows claims submission log, but I think this has more to do with what was going on with his case."

Amount in Dispute: $283.00

RESPONDENT'S POSITION SUMMARY

"As explained in the carrier's explanation of benefits, reimbursement was properly denied. Furthermore, the request for medical dispute resolution is not timely."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 17, 2018	CPT Code 99203	$283.00	$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 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced / denied by the respondent with the following claim adjustment reason codes:
   - Bill is denied; invalid/missing billing provider license number. Please re-submit with appropriate license number for review.
   - Bill is denied; invalid/missing referring provider license number. Please re-submit with appropriate license number for review.

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 October 17, 2018. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on October 24, 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

		11/08/2019
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 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.