



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

NUEVA VIDA BEHAVIORAL HEALTH

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number

M4-20-1973-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

APRIL 13, 2020

REQUESTOR'S POSITION SUMMARY

"CPT code 90885. Is recognized by Medicare and is listed in the Fee Schedule as being reimbursed at \$46."

Disputed Amount: \$34.00

RESPONDENT'S POSITION SUMMARY

"The Office respectfully requests the Division to dismiss the medical fee dispute resolution pursuant to Rule §133.307 (c)(1) as the requestor has failed to submit the medical fee dispute within one (1) year from the date of service and Rule §133.307 (f)(3)(A)."

Response Submitted By: SORM

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 7, 2019	CPT Code 90885	\$34.00	Not eligible for MFDR

AUTHORITY

This medical fee dispute is dismissed pursuant to 28 Texas Administrative Code §133.307(f)(3)(C).

Background

- 28 Texas Administrative Code (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 97-Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 243-The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
 - W3-Additional payment made on appeal/reconsideration.

- B20-Payment adjusted because procedure/service was partially or fully furnished by another provider.

Issue

Is the request for Medical Fee Dispute Resolution (MFDR) eligible for review in accordance with 28 TAC §133.307?

Findings

1. The requestor is seeking medical dispute resolution for CPT code 90885 rendered on April 7, 2019.
2. 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 DWC reviewed the submitted documentation and finds:

- The request for medical dispute resolution was received in MFDR on April 13, 2020.
- The disputed dates of service is April 7, 2019.
- The disputed services do not involve issues identified in §133.307(c)(1)(B).
- Date of service April 7, 2019 is past the one year deadline.
- Because the requestor did not file this dispute with MFDR within the one year deadline it is not eligible for MFDR.

Conclusion

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

Authorized Signature

		05/20/2020
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.