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
SAMUEL ALIANELL, MD

Respondent Name
MONTGOMERY COUNTY

MFDR Tracking Number
M4-20-1981-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
APRIL 14, 2929

REQUESTOR'S POSITION SUMMARY

"The Charges referenced herein were filed with the carrier and has neither been denied nor paid by the carrier at this time. We have contacted the carrier numerous times and they have maintained that they will look into in the issue and get back with us."

Disputed Amount: $2,343.40

RESPONDENT'S POSITION SUMMARY

"Based on the submitted documentation the request for MFDR should be dismissed. The Division should dismiss the request for MFDR because Requestor did not request reconsideration of Respondent's final action on an original bill which is required before provider can submit to MFDR. Although requestor asserts that it submitted the bills to a prior insurance carrier and then resubmitted them to the correct carrier there is no record of receiving those bills in question. A provider must request reconsideration of a carrier's final action as a prerequisite to requesting MFDR."

Response Submitted By: Injury Management Organization, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 9, 2019 November 19, 2019	CPT Code 99213	$150.00/each	$0.00
July 30, 2019 August 27, 2019	HCPCS Code G0482	$1,021.70/each	$0.00
TOTAL		$2,343.40	$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 (TAC) §133.307, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.20, effective January 29, 2009, sets out the health care providers billing procedures.
3. 28 Texas Administrative Code §133.250 sets out the medical bill processing and audit by insurance carriers procedures.
4. Neither party to the dispute submitted any explanation of benefits.

Issue

Are the disputed services eligible for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $2,343.40 for professional services rendered from May 9, 2018 through November 19, 2019.
2. The requestor wrote, "The Charges referenced herein were filed with the carrier and has neither been denied nor paid by the carrier at this time. We have contacted the carrier numerous times and they have maintained that they will look into in the issue and get back with us." In support of their position the requestor submitted copies of fax reports to York Risk Services and AS&G Claims.
3. The respondent wrote, "The Division should dismiss the request for MFDR because Requestor did not request reconsideration of Respondent's final action on an original bill which is required before provider can submit to MFDR. Although requestor asserts that it submitted the bills to a prior insurance carrier and then resubmitted them to the correct carrier there is no record of receiving those bills in question. A provider must request reconsideration of a carrier's final action as a prerequisite to requesting MFDR."
4. Whether the requestor's medical fee dispute is eligible for review relies upon whether the requestor satisfied the relevant prerequisite requirements as follows:

   - 28 TAC §133.307(c)(2)(J) requires the requestor to submit "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions)." The requestor did not submit any medical bills requesting reconsideration.

   - 28 TAC §133.307(c)(2)(K) requires the requestor to submit "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." The requestor did not submit any explanation of benefits.

   - 28 TAC §133.250(i) states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)."

   When read together, the requirements listed above obligate the requestor to provide proof that the medical bill for the services in dispute was appealed in accordance with §133.250.

   No documentation was found to support that the requestor sought reconsideration as required by 28 Texas Administrative Code §133.250(i). For that reason, the service in dispute is therefore not ripe for fee dispute resolution.

Conclusion

The DWC finds the requestor failed to submit the medical billing in dispute for reconsideration as required by Rule §133.307(c)(2)(J). Because the requestor failed to seek reconsideration for the disputed medical bills, the medical fee dispute is not eligible for review.

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

		5/7/2020
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.