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
VALIANT ANESTHESIA ASSOCIATES, PLLC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-21-1142-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
MARCH 9, 2021

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position summary.

Disputed Amount: $289.53

RESPONDENT'S POSITION SUMMARY

"Review of the claim file and bill history confirms VALIANT ANESTHESIA ASSOCIATES did not submit an appeal to Texas Mutual upon receiving the first denial."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 22, 2020	CPT Code 01630	$289.53	$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 TAC §133.250 sets out the medical bill processing and audit by insurance carriers procedures.
4. The services in dispute were reduced / denied by the respondent with the following claim adjustment reason codes:
   - CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 344-Reduction due to physician supervision of a qualified non-physician anesthetist.

- 790-This charge was reimbursed in accordance to the Texas medical fee guideline.

Issue

Is date of service September 22, 2020 eligible for medical fee dispute resolution in accordance with 28 TAC §133.307?

Findings

1. The requestor is seeking medical fee dispute resolution in the amount of $289.53 for professional services rendered on September 22, 2020.

   CPT code 01630 is described as "Anesthesia for open or surgical arthroscopic procedures on humeral head and neck, sternoclavicular joint, acromioclavicular joint, and shoulder joint; not otherwise specified."

   The respondent wrote, "Review of the claim file and bill history confirms VALIANT ANESTHESIA ASSOCIATES did not submit an appeal to Texas Mutual upon receiving the first denial."

   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)."

   - 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 TAC §133.250(i). For that reason, the service in dispute is therefore not ripe for fee dispute resolution.

Conclusion

The DWC finds that the requestor failed to submit the medical billing in dispute for reconsideration as required by Rule §133.307(c)(2)(J) for date of service September 22, 2020. Because the requestor failed to seek reconsideration for the disputed medical bill, the medical fee dispute for date of service September 22, 2020 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

		3/31/2021
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.