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
RAJESH GUTTA, DDS

Respondent Name
LIBERTY MUTUAL INSURANCE CO

MFDR Tracking Number
M4-21-1533-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
APRIL 30, 2021

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position summary.

Disputed Amount: $13,223.59

RESPONDENT'S POSITION SUMMARY

"This bills for DOS 07/14/2017 will not be reviewed as this dispute has been submitted past the timely filing deadline per Rule 133.307."

Response Submitted By: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 14, 2017	CPT Codes 21432 and 21390 (x2)	$13,223.59	$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 February 22, 2021, sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.307(c)(2)(K) requires health care providers to submit "each explanation of benefits or e-remittance (collectively "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 submitted an EOB but it did not list the CPT codes in dispute.
3. 28 TAC §133.307(d)(2)(B) requires the respondent to submit "all initial and appeal EOBs related to the dispute as originally submitted to the health care provider in accordance with this chapter, related to the health care in dispute not submitted by the requester, or a statement certifying that the

respondent did not receive the health care provider's disputed billing before the dispute request." The respondent did not submit any EOBs.

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 in the amount of $13,223.59 for CPT codes 21432 and 21390 (X2) rendered on July 14, 2017.
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 30, 2021.
   - The disputed date of service is July 14, 2017.
   - The disputed services do not involve issues identified in §133.307(c)(1)(B).
   - One year from July 14, 2017 is July 14, 2018.
   - The requestor did not file this dispute with the DWC's MFDR Section within the one-year deadline set out in 28 TAC §133.307.

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

		05/19/2021
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.