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
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-21-1537-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
APRIL 30, 2021

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position summary.

Disputed Amount: $5,062.29

RESPONDENT'S POSITION SUMMARY

"As documented by the Division date stamp, the Request was received on 04-30-2021, or more than three years late. Consequently, this Request for Medical Fee Dispute Resolution should be dismissed."

Response Submitted By: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 5, 2017	CPT Code 30420	$3,572.37	$0.00
	CPT Code 00170	$1,489.92	$0.00
TOTAL		$5,062.29	$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. The services in dispute were reduced / denied payment by the respondent with the following claim adjustment reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.

- 16-Claim/service lacks information which is needed for adjudication Additional information is supplied using remittance remarks codes whenever appropriate.
- 76-Billing is greater than surgical service fee.
- 110-Service cannot be reviewed without operative report and bill.
- 309-The charge for this procedure exceeds the fee schedule allowance.
- W3-Additional payment made on appeal/reconsideration.
- 863-Reimbursement based on applicable reimbursement fee schedule.
- T13-Medical necessity denial. You may submit a request for an appeal/reconsideration no later than 10 months from the date of service.
- 8765-No reimbursement made based on rule 133.250(b) reconsideration for payment of medical bills. The Health care provider shall submit the request for reconsideration no later than 10 months from the date of service.

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 $5,062.29 for CPT codes 30420 and 00170 rendered on January 5, 2017.
2. The respondent denied reimbursement for the disputed services based upon medical necessity denial reason code T13. The requestor submitted a copy of a preauthorization report that determined the disputed services were medically necessary; therefore, the respondent's denial is not supported.
3. 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 January 5, 2017.
   - The disputed services do not involve issues identified in §133.307(c)(1)(B).
   - One year from January 5 2017 is January 5, 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

Signature	Medical Fee Dispute Resolution Officer	06/01/2021 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.