TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
ELITE HEALTHCARE
GARLAND

Respondent Name
WEST BEND MUTUAL INSURANCE CO

MFDR Tracking Number
M4-22-1843-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
April 27, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 6, 2019	Codes 99204 and 99080-73	$3,254.85	$0.00
June 12, 2019	Code 97750-GP		
June 20, 2019	Codes 99213 and 99080-73		
July 9, 2019	Codes 99213 and 99080-73,		
July 23, 2019	Codes 99213 and 99080-73		
July 29, 2019	Code 99361-W1		
August 8, 2019	Codes 99213 and 99080-73		
August 29, 2019	Codes 99213, 99080-73 and 99361-W1		
September 12, 2019	Codes 99213 and 99080-73		
September 26, 2019	Codes 99213 and 99080-73		
October 15, 2019	Codes 99213 and 99080-73		
October 29, 2019	Codes 99213 and 99080-73		

November 08, 2019	Code 99361-W1		
November 12, 2019	Codes 99213 and 99080-73		
November 26, 2019	Codes 99213 and 99080-73		
December 17, 2019	Codes 99213 and 99080-73		
January 14, 2020	Code 99361-W1		
January 30, 2020	Codes 99213 and 99080-73		
February 6, 2020	Code 99361-W1		
	Total	$3,254.85	$0.00

These dates of service were denied payment **AGAIN** stating 'treatment is being denied relative to this workers compensation claim'. This is INCORRECT.

Amount in Dispute: $3,254.85

Respondent's Position

The Austin carrier representative for West Bend Mutual Insurance Co is JT Parker & Associates LLC. JT Parker & Associates LLC was notified of this medical fee dispute on May 3, 2022. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier [reduced or denied] the payment for the disputed services with the following claim adjustment codes:

- W3 – Bill is a reconsideration or appeal
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration
- 5902 – WB17: Treatment is being denied relative to this Workers Compensation Claim. We recommend you send future billing to the patients group health insurance carrier

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division 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 date of the services in dispute is January 6, 2019 to February 6, 2020. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on April 27, 2022. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

[redacted]	[redacted]	June 29, 2022
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 under 28 TAC

§133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.