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
PRS 3 LLC

Respondent Name
Travelers Indemnity Co.

MFDR Tracking Number
M4-23-3275-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
August 23, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 7, 2022	97161- INIT EVAL	$165.00	$0.00
	Total	$165.00	$0.00

Requestor's Position

"Called the adjuster on 6/12/23 and left message for call back. Sent another appeal on 6/16/23 since no response to previous appeal. Received denial from Travelers stating appeal denied. We submitted an appeal to to [sic] the SC Workers Compensation Board, but were told they did not have jurisdiction on this case. Per the denial from Travelers, reached out to TX WC and was told that would need to submit a Medical Fee Dispute Resolution Report."

Amount in Dispute: $165.00

Respondent's Position

"Without waiving the foregoing, the Carrier contends the Provider is not entitled to additional reimbursement. The Provider contends they timely submitted a properly coded bill to the Carrier. The Carrier reviewed the billing and issued a denial based on the procedure codes billed. The Carrier upheld this determination upon review of the request for reconsideration and contends the Provider is not entitled to additional reimbursement. The Carrier contends the provider is not entitled to reimbursement as they have waived the right to Medical Fee Dispute Resolution. The

Carrier, therefore, respectfully requests the Division dismiss this Request for Medical Fee Dispute Resolution as untimely filed, or in the alternative, determine no additional reimbursement is due for this service."

Response submitted by: Travelers

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 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- B16 – Payment adjusted because new patient qualifications were not met.
- 886 – The procedure was inappropriately billed. The provider has previously billed for an initial evaluation visit.
- 286 – Appeal time limits not met.
- W3 – Bill is a reconsideration or appeal.
- 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.

Issues

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

Findings

1. The requestor is seeking payment for professional medical services rendered in July 7, 2022. The insurance carrier denied the disputed services as new patient qualifications not met.
   DWC Rule 28 TAC §133.307(c)(1) states:

"Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the division receives the request.

(A) A request for medical fee dispute resolution 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.

(B) A request may be filed later than one year after the date(s) of service if:

(i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability;

(ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or

(iii) the dispute relates to a refund notice issued pursuant to a division audit or review; the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice.

The date of the service in dispute is July 7, 2022. The request for medical fee dispute resolution was received at the Division on August 23, 2023.

Review of the submitted documentation found insufficient evidence to support an exception as detailed above. The requestor has waived their right to MFDR.

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 reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 20, 2023 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.