



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

JONESBORO PROSTHETIC & ORTHOTIC LAB

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-17-3098-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

JUNE 20, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please accept this letter as an appeal for the denial of timely and no authorization on the above mentioned claim. We certainly agree with you that there was no authorization and that our claim was sent to you beyond the timely limit. However, we respectfully ask that you consider this as a one time exception due to the following circumstances that were beyond our control. We were originally told the Workers comp carrier for this claim was AIG. We filed a claim to them. Please see enclosed the letter from AIG stating they did not have this claim. At that point, we were given Cypress Care information. We tried for several months to get claim status from Cypress Care with no return phone call. I finally sent an e-mail to a supervisor who responded with they had no claim on file. Once I spoke with the supervisor, I was able to obtain the correct insurance information. Unfortunately, we could not obtain a retro auth."

Amount in Dispute: \$1,164.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "One year from disputed date 11/23/15 is 11/23/16. The TDI/DWC date stamp lists the received date as 6/26/17 on the requestor's DWC-60 packet, a date greater than one year from 11/23/15. The requestor has waived its right to DWC MDR."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 23, 2015	HCPCS Code L1845	\$1,164.00	\$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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. The services in dispute were reduced/denied by the respondent with the following reason codes:
- CAC-138-Appeal procedures not followed or time limits not met.
 - CAC-18-Exact duplicate claim/service.
 - CAC-197-Precertification/authorization/notification absent.
 - CAC-29-The time limit for filing has expired.
 - W3-Additional reimbursement made on reconsideration.
 - CAC-193-Original payment decision is being maintained. This claim was processed properly the first time.
 - 29-The documentation submitted did not provide convincing evidence to support the position that his bill was submitted timely to the Workers' Compensation carrier.
 - 731-Per rule 133.20(b), except as provided in Labor Code 408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided.
 - 879-Per TDI/DWC rule 133.250(b). The health care provider shall submit the request for reconsideration no later than ten months from the date of service.
 - 891-No additional payment after reconsideration.

Issue

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

Findings

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 November 23, 2015. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on June 20, 2017. 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 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 Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

07/06/2017

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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 Division. **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.