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
KLEYPAS, ROBERT W.

Respondent Name
STATE OFFICE OF RISK MANAGEMEN

MFDR Tracking Number
M4-14-2093-01

Carrier's Austin Representative Box
Box Number: 45

MFDR Date Received
February 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Faxed pre-authorization for crown on 1/16/13 to case worker Amy Thomas. Also included Dr. Kleypas W-9 form. Received letter from State Office of Risk Management stating claim was not complete. (Billing provider's name). Providers name and tax id was on all forms submitted Oct 23, 2013 – spoke with Amy Thomas confirming that fax was received showing all paperwork was submitted in correct timeframe."

Amount in Dispute: $1373.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The office found the requestor's first submission of their bill for date of service 1/24/13 was received on 6/25/13, the bill was reviewed and it was determined that the provider's tax id was not set up on the State Comptrollers Vendor system and the DWC prescribed form was incomplete, the bill was returned to the provider on 6/28/2013 for corrections to their billing form and a request for the provider to complete a W9 and Ap152 form so that the provider could be set up in the State Comptrollers Vendor Maintenance system. On 8/28/2013 the Office received another submission for the requestor's bill and determined that this submission was submitted on the wrong form and was returned to the provider on 8/28/2013."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 24, 2013 and January 25, 2013	CPT Code D2740	$1373.00	$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 health care providers to pursue a medical fee dispute.

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 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 MDR Section 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." The date of the services in dispute is January 24, 2013 and January 25, 2013. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on February 27, 2014

. 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, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR 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. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	5/2/14 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.