



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

STEVE SACKS, MD

Respondent Name

AMERICAN HOME ASSURANCE CO

MFDR Tracking Number

M4-15-1903-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

FEBRUARY 24, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to AIG on 11-17-2014, this request was in response to a \$725.61 reduction of the \$918.58 for the EMG performed on 2-11-2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: \$749.22

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's position that we do owe additional money to the requestor...The bills have been processed on 4/15/2014 where \$169.36 was paid. On 3/4/2015 the bill was again processed and recommended a total payment of \$826.02. A check in the amount of \$656.66 is on hold because of an inactive Tax ID since 9/16/2014. Our billing department is in the process of obtaining a W9 so the check can be issued."

Response Submitted by: AIG Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 11, 2014	CPT Code 99203 Office Visit	\$23.61	\$0.00
	CPT Code 95886	\$302.62	\$0.00
	CPT Code 95886	\$397.99	\$0.00
	HCPCS Code A4556 Electrodes	\$25.00	\$0.00
TOTAL		\$749.22	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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:
 - W1-Workers compensation state fee schedule adjustment.
 - VRNA-No reduction available.
 - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - P300-The amount paid reflects a fee schedule reduction.
 - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - Z710-The charge for this procedure exceeds the fee schedule allowance.
 - U058-Procedure code should not be billed without appropriate primary procedure.
 - VA02-Invalid number of units.
 - B291-This is a bundled or non covered procedure based on Medicare guidelines; no separate payment allowed.

Issue

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 service in dispute is February 11, 2014. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on February 24, 2015. This date is later than one year for date 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 disputed services.

Authorized Signature

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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 in accordance with 28 Texas Administrative Code §133.307, 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 MFDR 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.