



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

JAY C PROCTOR MD

Respondent Name

OLD REPUBLIC INSURANCE CO

MFDR Tracking Number

M4-15-2201-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

MARCH 19, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was originally sent out on 2/24/14 by mail. I am enclosing a copy of the claim. Please reconsider this as proof of timely filing on both dates of service."

Amount in Dispute: \$430.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This request for Medical Fee Dispute Resolution was not timely filed pursuant to DWC Rule 133.307(c) with regard to the date of service 2/24/14. The denial of the medical bill for the date of service 2/24/14 does not contain a related compensability, extent of injury or liability dispute. Therefore, this request for Medical Fee Dispute Resolution for that date was not timely filed within one year of the date of service... With regard to the date of service 2/24/14, the request for medical dispute resolution filed on 3/19/15 was not gamely filed. With regard to the date of service 6/19/14, Respondent has paid Requestor the amount billed. Please see the attached EOB and payment information."

Response Submitted by: DOWNS-STANFORD, PC

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include February 24, 2014 and June 19, 2014.

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. 28 Texas Administrative Code §134.203 sets out the guidelines for payment of medical services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 29 – The time limit for filing has expired.
  - 937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95<sup>th</sup> day after the date of service.
  - W3 – Additional payment made on appeal/reconsideration.
  - 5094 – DWC requires request for reconsideration or corrected claim to be submitted within 10 months of the date of service.

**Issues**

1. Did the requestor waive the right to medical fee dispute resolution for date of service February 24, 2014?
2. Did the insurance carrier submit documentation to support payment was made for date of service June 19, 2014?

**Findings**

1. 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 service in dispute is February 24, 2014. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on March 19, 2015. 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.
2. CPT Code 99213 for date of service, June 19, 2014 was initially denied using "29 – The time limit for filing has expired" and "937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95<sup>th</sup> day after the date of service." Review of the documentation submitted by the respondent finds that the insurance carrier has issued payment of \$100.00 for the disputed issue and date of service under document number 1423359 in accordance with 28 Texas Administrative Code §134.203.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

***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**

|           |  |             |
|-----------|--|-------------|
| Signature | Medical Fee Dispute Resolution Officer | Date        |
|           |  | May 6, 2015 |

### ***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.**