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 PROCTOR MD

**Respondent Name**
STATE OFFICE OF RISK MANAGEMENT

**MFDR Tracking Number**
M4-15-2500-01

**Carrier's Austin Representative**
Box Number 45

**MFDR Date Received**
APRIL 10, 2015

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "As I am working unpaid claims, I came across [injured worker] and I searched the online EOB which stated there was not a claim for this DOS. There is proof of timely filing. Please reconsider this bill for payment."

**Amount in Dispute:** $300.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Upon notification of this dispute the Office performed a review of the medical billing received from Jay Proctor MD, which revealed that an erroneous audit has been performed for date of service 9/24/2014. The Office has requested an immediate re-audit for date of service 9/24/2014 to allow payment pursuant to the Division's rules and payment policies to include applicable interest. The Office respectfully requests the Division deem the disputed charges for dates of service 2/11/2014 and 2/17/2014 are not eligible for review as the Office found that dates of service are not filed within the time frame set forth by the Division to file a medical dispute pursuant to Rule 133.307(c)(1)(A)."

**Response Submitted by:** STATE OFFICE OF RISK MANAGEMENT

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| February 11, 2014<br>February 27, 20214 | CPT Code 99213 | $200.00 | $0.00 |
| September 24, 2014 | CPT Code 99213 | $100.00 | $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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired.
   - 927 – 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 95th day after the date of service.

**Issues**

1. Is date of service September 24, 2014 still in dispute?
2. Are dates of service February 11, 2014 and February 27, 2014 untimely and did the requestor waive the right to medical fee dispute resolution?

**Findings**

1. Review of the documentation submitted by the respondent and communication with the requestor finds that date of service September 24, 2014 was paid. Therefore a dispute not longer exists for this date of service.
2. 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 dates of the service in dispute are February 11, 2014 and February 24, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on April 10, 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(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**

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**

| | | June 19, 2015 |
|---|---|---|
| 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, 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 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**.