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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TIMOTHY MARKS MD

Respondent Name
CHUBB INDEMNITY CO

MFDR Tracking Number
M4-15-2695-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
April 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting a medical Fee Dispute Resolution in accordance with 28 TAC 133.307 (c)(2).

Findings of Fact.

On 11/4/13 I filed my 1st RFR. The claim was denied due to supporting documentation. On 12/4/13 the IC denied payment due to unsupported service and claimed the CMS 1500 was incomplete. On 1/16/14 I filed my second RFR, and attached supporting documentation and the completed CMS 1500 claim form. On 3/11/14 this was re-submitted. On 5/30/14 the IC decided to denied do to timely filing. On 8/18/14 I filed a RFR showing that his was not a timely filing issue either. On 12/17/14 I filed a request for an IRO. The carrier has refused to respond to my IRO.

Therefore, I am requesting a MDR."

Amount in Dispute: $275.00

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). The date of service at issue in this matter is 6/13/13 …

Medical Fee Dispute Resolution received Requestor's DWC-60 on 4/17/15 as evidenced by the date stamp on the DWC-60. As the date of service in dispute is 6/13/13, Respondent requests Medical Fee Dispute Resolution enter a Findings and Decision stating Requestor waived their right to dispute resolution as the request was not filed within one year of the date of service.

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 2013	CPT Code 99214	$275.00	$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:
   - RM2 – Time limit for filing claim has expired
   - 29 – Time limit for filing claim/bill has expired
   - W3 – Appeal/Reconsideration

Issues

1. 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 the service in dispute is June 13, 2013. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on April 17, 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

		7/17/15
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.