



# 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**

TIMOTHY MARKS MD

**Respondent Name**

HOUSTON ISD

**MFDR Tracking Number**

M4-16-1595-01

**Carrier's Austin Representative**

Box Number 44

**MFDR Date Received**

February 08, 2016

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "To whom this may concern: I am requesting a medical Fee Dispute Resolution in accordance with 28 TAC 133.307 (c)(2). Required documentation is attached.

- A copy of the medical bills. Exhibit "A"
- A copy of the medical bills submitted to the IC for re-consideration. Exhibit "B"
- A copy of the EOB's Exhibit "C"
- A copy of the final decision regarding compensability, extent of injury etc. Exhibit "D"
- A copy of the medical records. Exhibit "E"
- A copy of the position statement of the disputed issues. Exhibit. "F"."

**Amount in Dispute:** \$550.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "...Requestor rendered these services in 2014. Requestor filed the Request for Medical Fee Dispute Resolution with the Division on February 8, 2016, according to the Division's date-stamp. This Request was submitted more than one year following the dates of service in 2014. None of the submitted documentation indicates that: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed; (ii) that a medical dispute regarding medical necessity was filed less than 60 days before Requestor files the Request; or (iii) that the dispute relates to a refund notice issued pursuant to a division audit or review."

**Response Submitted by:** WHITE ESPEY PLLC

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 05, 2013; October 10, 2013; October 22, 2013; December 19, 2013; January 23, 2014; August 21, 2014 and November 26, 2014	CPT Codes 99358, 99215, 99205 and 99214	\$550.00	\$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:
  - 147 – Provider contracted/negotiated rate expired or not on file

### **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 services in dispute is September 05, 2013; October 10, 2013; October 22, 2013; December 19, 2013; January 23, 2014; August 21, 2014 and November 26, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on February 08, 2016. 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**

Signature	Medical Fee Dispute Resolution Officer	3/23/2016 Date
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## ***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.**