



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

JASON BAILEY MD

Respondent Name

CASTLEPOINT NATIONAL INSURANCE

MFDR Tracking Number

M4-16-1673-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

February 17, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a request for investigation into the payment of the claim referenced above. According to 28 TAC §134.2, 134.203, and 134.204 for the year 2013 Dr. Bailey should have been compensated for the services he provided at 204% of the listed Medicare Allowable rates. He was not.

Using the CMS Physician Fee Schedule – Search Results attached for your reference, this office has calculated that at 204% Dr. Bailey should have been paid \$1321.17. Instead he was paid \$1052.65. This is an underpayment of \$268.52. This information alone is sufficient support for our dispute."

Amount in Dispute: \$268.52

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 dates of service at issue in this matter are 3/28/13 and 4/8/13 ...

Medical Fee Dispute Resolution received Requestor's DWC-60 on 2/17/16 as evidenced by the date stamp on the DWC-60. The dates of service in dispute are 3/28/13 and 4/8/13, and the attached EOBs do not reflect any extent, liability or medical necessity issues. Therefore, 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 PC

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 28, 2013 and April 08, 2013; CPT Codes 99284, 13152 and 99212; \$268.52; \$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:
- 1 – The amount paid reflects a fee schedule reduction
  - 2 – The charge for this procedure exceeds the fee schedule allowance

**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 March 28, 2013 and April 08, 2013. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on February 17, 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

\_\_\_\_\_  
3/11/2016  
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.**