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
WILLIAM URSPRUNG, DC

Respondent Name
IMPERIUM INSURANCE CO

MFDR Tracking Number
M4-19-0657-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
OCTOBER 04, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $1,315.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is seeking reimbursement of $1,315.00. We are attaching proof of payment in the amount of $1,334.65 for the services in question which include the principal and interest. The check was issued on October 19, 2018."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2018	CPT Code 99456-W5-WP (X2)	$800.00	$0.00
	CPT Code 99456-W8-RE	$500.00	$0.00
	CPT Code 99080-73	$15.00	$0.00
TOTAL		$1,315.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
2. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
3. The services in dispute were reduced / denied by the respondent with the following reason codes:
   - 29-The time limit for filing has expired.
   - 4271-Per TX Labor Code Sec. 413.016. Providers must submit bills to payors within 95 days of the date of service.

Issues

Did the requestor support position that the disputed bills were submitted timely? Is the requestor entitled to additional reimbursement?

Findings

According to the explanation of benefits, the respondent denied reimbursement for CPT codes 99456-W5-WP, 99456-W8-RE and 99080-73 based upon reason codes: "29-The time limit for filing has expired," and "4271-Per TX Labor Code Sec. 413.016. Providers must submit bills to payors within 95 days of the date of service." The respondent states, "The provider is seeking reimbursement of $1,315.00. We are attaching proof of payment in the amount of $1,334.65 for the services in question which include the principal and interest. The check was issued on October 19, 2018."

The division finds the respondent did not maintain the denial and issued payment for the disputed services.

The Division concludes that the carrier changed its original final action and decided to reimburse the requestor for the disputed amount. For that reason, the Division moves to resolve this dispute with the information available and concludes that no additional reimbursement can be recommended.

Conclusion

The Division concludes that Memorial has already been paid for the service in dispute. 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	12/07/2018 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 MDR 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.