



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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

NIMESH PATEL, MD

Respondent Name

ACE AMERICAN INSURANCE CO

MFDR Tracking Number

M4-19-3227-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

FEBRUARY 21, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please review that attached as 2nd reconsideration and reconsider for payment on code 99214. We are an urgent care facility and do not perform surgeries, therefore this visit should have paid on 99214 as a follow up."

Amount in Dispute: \$320.14

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the date of service at issue is outside of the one-year deadline and the Division lacks jurisdiction to consider this dispute."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 29, 2017	CPT Code 99214	\$195.14	\$0.00
	CPT Code 99080	\$25.00	\$0.00
	CPT Code S9088	\$100.00	\$0.00
TOTAL		\$320.14	\$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. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced / denied by the respondent with the following reason code:

- 127-This visit falls within the surgical follow-up days of another procedure
- 148-This procedure on this date was previously reviewed.
- 779-Items, codes and services that are not covered by Medicare.
- 18-Duplicate claim/service.
- 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- P12-Workers compensation jurisdictional fee schedule adjustment.

Issue

Did the requestor waive the right to medical fee dispute resolution?

Findings

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 service in dispute is June 29, 2017. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on February 21, 2019. 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 for these services.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute for those dates have not been addressed.

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 services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	3/06/2019 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 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.