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 STRINDEN MD

Respondent Name
INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-19-4280-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
May 29, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am writing to request additional payment for the abovementioned date of service because you did not pay the maximum allowable reimbursement (MAR). According to the Texas Workers Comp Fee Schedule, the MAR is calculated on the medicare RVU's taking into consideration the geographic indices and the 2018 conversion factor for outpatient facility which is 73.19... Prompt review and additional payment of $402.88 for date of service 01/09/18 would be appreciated."

Amount in Dispute: $402.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider sent EOP [attached] on 12/21/2018 with payment of $3040.57 for CPTs 15100, 15101 x2, 15002, 15003 x2, and 13160... Provider did not submit an appeal until 3/15/2019 [see attached appeal document with fax cover sheet]. Therefore, denied as Z903- Date of service exceeds 10-month time period for submission per Rule 133.250 (b). (Z903). DOS was 1/9/18."

Response Submitted by: Helmsman Management Services, LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2018	15101-58 x 2, 15002-58, 15003-58 x 2, 13160-58-59	$402.88	$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:
   Explanation of Benefits dated May 15, 2019
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment. Previously paid.
   - 107 – Staged/related procedure performed by same physician during postoperative period
   - 78 – The allowance for this procedure was adjusted in accordance with the multiple surgical procedure rules and/or guidelines
   - 86 – Service performed was distinct or independent from other services performed on the same day

Issues

1. Did the requestor submit the dispute in accordance with 28 Texas Administrative Code 133.307 (c)(1)(B)(i)?
2. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307 states in pertinent part, "(c) Requests. Requests for MFDR shall be filed in the form and manner prescribed by the division. Requestors shall file two legible copies of the request with the division. (1) 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... (B) A request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability..."

   The requestor states, "Insurance delayed claim payment until 12/31/18 while compensability was being determined. Reconsideration sent on 3/4/19. Just received response made on 5/15/19. MFD sent 5/28/19. Ins. Did not pay MAR."

   The requestor submitted insufficient documentation to support that the dispute was submitted within 60 days after the date the requestor received the final decision, inclusive of all appeals, on compensability, extent of injury, or liability. The Division therefore finds that the disputed services were submitted untimely to MFDR for review.

2. The requestor seeks reimbursement for medical services rendered on January 9, 2018. 28 Texas Administrative Code §133.307(c) (1) states in pertinent part, "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 January 9, 2018. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on May 29, 2019. 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

		July 3, 2019
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. A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** for **DWC045M** in accordance with the instructions on the form. The request must be received by the Division within **twenty (20)** 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