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
MICHAEL HECKMAN, MD

Respondent Name
INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number
M4-19-5381-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
AUGUST 30, 2019

REQUESTOR'S POSITION SUMMARY

"We are asking for a reconsideration of code 20611 for date of service 03/16/18. [Claimant] was approved for evaluation and treatment. After the evaluation was completed it was decided an injection would be beneficial for pain control. This injection (20611) should have been paid as a separate procedure. We are also asking for a reconsideration for code 99080. As this was the initial visit for the patient a work status form was completed and sent with the claim."

Amount in Dispute: $1,609.40

RESPONDENT'S POSITION SUMMARY

The DWC-60 was filed with he Division on August 30, 2019. The provider's DWC-60 was required to be filed no later than one year following the date of service."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2018	CPT Code 20611	$200.00	$0.00
	CPT Code 99080	$20.00	$0.00
TOTAL		$220.00	$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 (DWC).

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 claim adjustment reason codes:
   - P12-Workers compensation jurisdictional fee schedule adjustment.
   - P300-the amount paid reflects a fee schedule reduction.
   - 112-Service not furnished directly to the patient and/or not documented.
   - Z559-Reimbusement has paid in the Texas Division of Workers Compensation Rules, Chapter 129 rule 129.5(a)-(J).

Issue

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

Findings

28 TAC §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the DWC's MFDR Section or waive the right to MFDR. The DWC 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 March 16, 2018. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on August 30, 2019. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The DWC concludes that the requestor has failed to timely file this dispute with the DWC's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for these services.

Conclusion

The DWC finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 TAC §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 DWC has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	09/26/2019 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **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.