



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Igor Rakovchik, DO

Respondent Name

Dallas County

MFDR Tracking Number

M4-24-2149-01

Carrier's Austin Representative

Box Number 17

Date Received

June 5, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 5, 2022	99204	\$484.00	\$0.00
December 5, 2022	95886	\$1,400.00	
December 5, 2022	95913	\$3,150.00	
Total		\$5,034.00	\$0.00

Requestor's Position

"We are writing in response to your explanation of bill review that we received regarding the above-mentioned patient stating that the time limit for filing claim/bill has expired. We submitted the bill originally December 6th, 2022, and we received no response which is why the claim was resubmitted to you on September 26th, 2023. I have attached the original claim form with the original date of December 6th, 2022, for your reconsideration."

Amount in Dispute: \$5,034.00

Respondent's Position

"Medical Fee Dispute Resolution received Requestor's DWC-60 on 6/05/2024, as evidenced by the date stamp on the DWC-60. The date of service in dispute is 12/05/2022, 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

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code ([TAC](#)) [§133.305](#) sets out the procedures for resolving medical disputes.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier denied the payment for the disputed services with the following claim adjustment codes:

- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- 29 – Time limit for filing has expired.
- 1014 - The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 5094 - DWC requires request for reconsideration or corrected claims to be submitted within 10 months of the date of service.
- 193 - Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Bill is a reconsideration or appeal.

Issues

Has the requestor waived their right to medical fee dispute resolution?

Findings

The requestor seeks payment in the amount of \$5,034.00, for medical services provided on December 5, 2022.

28 TAC §133.307 (c) (1) states in the pertinent part, "Timeliness. A requestor must timely file the request with the division or waive the right to MFDR. The division will deem a request to be filed on the date the division receives the request. A decision by the division that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section."

The service in question was performed on December 5, 2022. The medical fee dispute was received by the Division on June 5, 2024. This date is more than a year following the in-question date(s) of service.

28 TAC §133.307 (c) (1) (A) states, "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."

A review of the submitted documentation finds that the disputed service(s) does not involve issues identified in 28 TAC §133.307 (c) (1) (B). The Division concludes that the requestor has failed to timely file this dispute with the Division; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been included, it was considered.

The Division finds the requestor has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, the Division has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	July 1, 2024
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. The Division must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to the Division using the contact information on the form or the field office handling the claim. If you have questions about the DWC Form-045M, call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must 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*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.