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
AMERICAN HOME ASSURANCE COMPANY

Respondent Name
PMSI

MFDR Tracking Number
M4-07-2603-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 2, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per APD 9/25/06, the hearing officer's decision and order became final that the compensable injury does not extend to and include right carpal tunnel syndrome and right wrist tendonitis therefore, the Carrier respectfully requests a refund in the amount of $346.67."

Amount in Dispute: $346.67

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The health care provider did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 21, 2006	Insurance Carrier Request for Refund	$346.67	$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. Former 28 Texas Administrative Code §133.304 sets out the procedures for medical payments and denials.

Issues

1. Did the insurance carrier timely request reimbursement for an overpayment from the health care provider?

Findings

1. This dispute relates to an insurance carrier request for a refund from the health care provider subject to the procedures set forth in former 28 Texas Administrative Code §133.304, effective July 15, 2000, 25 *Texas Register* 2115, which requires, in pertinent part, that:
   (a) Except as provided in subsections (d) and (e) of this section, an insurance carrier shall take final action on a medical bill not later than the 45th day after the date the insurance carrier received a complete medical bill.
   (b) Final action on a medical bill includes one or more of the following:

(1) sending payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §133.1(8) of this title (relating to Definitions for Chapter 133, Benefits--Medical Benefits);
(2) denying a charge on the medical bill; or
(3) requesting reimbursement for an overpayment.

Review of the submitted information finds that the insurance carrier received the medical bill on May 25, 2006. The insurance carrier's request for a refund is dated October 10, 2006. This is later than the 45th day after the date the insurance carrier received the complete medical bill. Accordingly, the Division finds that the insurance carrier has not met the requirements of §133.304(b)(3). Reimbursement is therefore not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor failed to timely request reimbursement of an overpayment from the health care provider. Consequently, the requestor has failed to establish that 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 services in dispute.

Authorized Signature

	Grayson Richardson	November 4, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.