



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

DR LENA BRUCE

**Respondent Name**

ACE INSURANCE CO OF TEXAS

**MFDR Tracking Number**

M4-11-4857-01

**Carrier's Austin Representative Box**

Box Number 15

**MFDR Date Received**

August 19, 2011

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "claim submitted electronically and never paid."

**Amount in Dispute:** \$1,788.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The DWC-60 from the Requestor lists the dispute as a fee dispute and includes treatment provided by the Requestor for the past 3 years which have been denied as they were not billed on the correct billing form...The dispute was received by Medical Fee Dispute Resolution on 8/18/11...fee disputes must be filed within one year of the dates of service..."

**Response Submitted by:** Downs Stanford P.C.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 18, 2008 through December 26, 2011	E/M Services	\$1,788.00	\$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.

#### **Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- The services in dispute were reduced/denied by the respondent with the following reason codes:  
Explanation of benefits
  - 1-(45) charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
  - 1-Please resubmit charges on the appropriate billing form. (XB76).
  - 716-Payment denied due to alternative vendor claim status.
  - A1-Claim/service denied.

#### **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 with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution 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 dates of the services in dispute are November 18, 2008 through December 26, 2011. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on August 19, 2011. In part, 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, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR 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 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**

		May 13, 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.**