



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

TEXAS ALLIANCE MEDICAL GROUP

Respondent Name

INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number

M4-13-1168-01

Carrier's Austin Representative Box

Box Number 19

MFDR Date Received

JANUARY 11, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: [REDACTED] is the employer for this claimant, they initially had us to bill directly to their offices @ Staffmark Galleria 2500 West Loop S #130, Houston, TX 77027 then one of their representatives called and asked us to mail the claims to another carrier address New Hampshire Insurance Company 70 Pine Street New York, NY 10270, then from the denial we were told that Avizent was handling the claims and to resubmit to P.O. Box 182364 Columbus, Ohio 43218-2364 now we have been told by Avizent to submit the bills to CCSI the address is listed above..."

Amount in Dispute: \$2,899.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier is reviewing DOS for any appropriate reimbursement [sic]."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 5, 2001 through March 22, 2012	Professional Services	\$2,899.00	\$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 resolving medical fee disputes.
- 28 Texas Administrative Code §133.20 sets out the procedures for medical bill submission by the health care provider.

Issues

- Did the requestor bill the injured workers employer?
- Is the requestor entitled to reimbursement?

Findings

1. According to the requestor's position summary, they initially billed the injured workers employer. According to 28 Texas Labor Code § 133.20(j), the health care provider may elect to bill the injured employee's employer if the employer has indicated a willingness to pay the medical bill(s). Such billing is subject to the following: (1) A health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to: (C) medical dispute resolution as provided by Labor Code §413.031.
2. Medical Fee Dispute Resolution is unable to adjudicate this dispute; therefore, no reimbursement is ordered.

Conclusion

For the reasons stated above, the Division finds that the reimbursement is not recommended. 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

Signature

Medical Fee Dispute Resolution Officer

October 20, 2014
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 Division within **twenty** 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 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 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.