



# 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**

WM J KOWALSKI DC

**Respondent Name**

TPS JOINT SELF INS FUNDS

**MFDR Tracking Number**

M4-14-0485-01

**Carrier's Austin Representative**

Box Number 11

**MFDR Date Received**

October 10, 2013

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "This patient was seen by me for the purpose of evaluation. She was found to be at MMI as of 03-14-13 for her injuries sustained on the above mentioned date. Based upon my evaluation she has sustained a 0% IR for her condition. Her IR is based upon the AMA Guides 4<sup>th</sup> edition Her Impairment 0% is based upon Lumbosacral Spine DRE Category I. Therefore, the above mentioned patient has a 0% IR with an MMI date of 03-23-13 for her lower back injury of 01-08-13-see attached work-sheet."

**Amount in Dispute:** \$375.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "We are in receipt of the Medical Dispute Resolution DWC 60 concerning claimant [injured employee] from William John Kowalski, DC. For date of service 04/11/13. Based on the submitted documentation no additional recommendation is being made at this time.

In reviewing the submitted records and based on Rule §133.20, we are denying the bill based on untimely submission. We have never received the bill in question and the provider has not submitted acceptable proof of timely filing per rule 408.0272."

**Response Submitted by:** IMO

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11, 2013	Maximum Medical Improvement and Impairment Rating Examination	\$375.00	\$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.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - No Explanation of benefits provided

**Issues**

1. Did the requestor file the disputed services in accordance with 28 Texas Administrative Code §133.307?
2. Is the requestor entitled to reimbursement?

**Findings**

1. 28 Texas Labor Code §133.307 (c)(2)(K) states “a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB.”  
Review of submitted documentation provided by the requestor finds Explanation of Review for dates of service February 05, 2013 through March 14, 2013 which are not related to the disputed service of April 11, 2013. No convincing documentation found for the disputed service in dispute for April 11, 2013 as required above.
2. For the reasons stated above, The Division has concluded no additional reimbursement is due to the requestor.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional 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**

	Sandra Hernandez	9/12/14
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 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.**