



**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**

SOUTH TEXAS RADIOLOGY GROUP  
 C/O ANGELA GUTIERREZ

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-14-0999-01

**Carrier's Austin Representative Box**

Box Number: 54

**MFDR Date Received**

DECEMBER 2, 2013

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Patient provided Texas Mutual Workers Comp information. We have already attended several BRcs [sic] & CCH for Extent of Injury. The extent issue has been resolved & CCH decision was in the injured worker's favor. Now our Emergency Room Services are being denied for lack of preauthorization. We are asking TDI to review this situation and determine whether or not the insurance carrier is liable for this claim."

**Amount in Dispute:** \$145.85

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "One year from disputed date 3/24/12 is 3/24/13. The TDI/DWC date stamp lists the received date as December 2, 2013 on the requestor's DWC-60 packet, a date greater than one year from 3/24/12. The requestor has waived its right to DWC MDR. No payment is due."

**Response Submitted by:** Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2012	CPT Codes 70450 and 72125	\$145.85	\$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. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

**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 date of the services in dispute is March 24, 2012. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on December 2, 2013. 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 involve issues identified in §133.307, subparagraph (B). The requestor submitted a copy of the last page of a decision and order signed by Roy H. Leonard, Hearing Officer on January 2, 2013. The decision and order of the Hearing Officer was upheld by the Appeals Panel on April 19, 2013. In accordance with 28 Texas Administrative Code §133.307(B)(i) a related compensability, extent of injury or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor received the final decision, inclusive of all appeals, on compensability, extent of injury, or liability. 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**

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
April 24, 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.**