Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
JOHN F GARVISH MD

Respondent Name
ZENITH INSURANCE CO

MFDR Tracking Number
M4-14-1991-01

Carrier's Austin Representative Box
Box Number 47

MFDR Date Received
March 6, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We were not notified until 10/29/20/13 [sic] that this was worker's comp even though after the patient's initial services we sent the patient several bills which the patient did not respond. Upon this notification we filed claim immediately to the Texas Migrant Council as instructed by Mike Reed. Prior to billing the Texas Migrant Council we billed the patient directly for our services because the patient did not provide the rendering facility with any worker's comp information. Once we learned that this was worker's comp we called the employer that notified us that this claim was supposed to be filed as a worker's comp and they instructed us to file a bill directly to them."

Amount in Dispute: $422.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "John Garvish MD has requested review of his bill submission due to the denial of services due to the bill being submitted more than 95 days after the date of service... Zenith Insurance Company has reviewed the provider's Medical Fee Dispute Resolution Request and has determined that no payment is due pursuant to Labor Code 408.027 (s).""

Response Submitted by: The Zenith

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 20, 2013	70450, 71020, 72040, 72070, 72100 and 72190	$422.00	$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.

Issue
Did the requestor waive the right to medical fee dispute resolution?

Findings

Per 28 Texas Administrative Code §133.20(j)(1)(C), a health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the right to medical dispute resolution as provided by Labor Code §413.031. Review of the submitted information finds that the requestor submitted the medical bills for the services in dispute to the injured worker's employer. The Division therefore concludes that the requestor has waived the right to medical fee dispute resolution.

Conclusion

The requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the medical fee issues have not been addressed. 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

Signature	Medical Fee Dispute Resolution Officer	November 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.