



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

CHRISTUS NEW BRAUNFELS

Respondent Name

SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number

M4-15-0828-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

November 03, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "PLEASE REVIEW THE ATTACHED DOCUMENTATION FOR THE ABOVE REFERENCED CLAIM WHICH WAS DENIED AS PAST TIMELY FILING. WE REQUEST AFTER YOUR REVIEW OF THE ATTACHED PROOF OF TIMELY FILING THIS DENIAL BE OVERTURNED AND THE WORK COMP CARRIER BE INSTRUCTED TO PROCESS THE CLAIM FOR PAYMENT.

WE FEEL THE TIMELY FILING OF THIS CLAIM WAS ATTEMPTED WITH ALL DUE DILIGENCE USING THE INFORMATION PROVIDED TO THE FACILITY AND INCLUDING FILING BY CERTIFIED MAIL OF THE ORIGINAL CLAIM."

Amount in Dispute: \$8,371.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on January 2, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review

Response Submitted by: na

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 26, 2012	Outpatient Hospital Services	\$8,371.50	\$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 resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 29 – Time limit for filing claim/bill has expired
 - TC – Technical component
 - W3 – Appeal/reconsideration
 - 193 – Original payment decision maintained
 - B15 – Procedure/Service is not paid separately
 - TC – Technical component

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR 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 October 26, 2012. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on November 03, 2014. 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(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR 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, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

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	1/30/15 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.

