TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CENTER FOR OCCUPATIONAL HEALTH

Respondent Name
SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number
M4-15-2960-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 12, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have attached the signed authorization and all correspondence regarding this claim. Please review and forward to the appropriate department for payment."

Amount in Dispute: $400.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on evidence submitted in requestor's dispute packet the injured employee's workers' compensation claim was originally filed under the Oklahoma Workers' Compensation Program since he was injured in Oklahoma's jurisdiction. Moreover, based on further evidence submitted by Center for Occupational Health, authorization for treatment and billing was submitted to the injured employee's employer for reimbursement. It was not until 03/23/15 that Service Llyods Insurance Company received a medical bill for ate of service 05/12/14. A medical bill review was conducted and final action issued in the form of a denial for past the filing deadline and entitlement to benefits."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
May 12, 2014 and May 30, 2014	99204, 99080 x 2, 99213, 20610 and J3301	$400.80	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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.

Findings

The Division's Medical Fee Dispute Resolution (MFDR) section is unable to resolve this dispute. Per 28 Texas Administrative Code §133.307(a)(3), "In resolving non-network disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the Division of Workers' Compensation (Division) is to adjudicate the payment, given the relevant statutory provisions and Division rules." Upon review, the submitted documentation supports that the injured employee has received benefits under the worker's compensation laws of the state of Oklahoma. Consequently, this fee dispute is not within the jurisdiction of the Division of Workers' Compensation, as it does not involve a Texas workers' compensation claim. The Division therefore finds that the requestor does not have the right to file for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

Conclusion

The Division concludes that it does not have jurisdiction over the services in dispute. This request for medical fee dispute resolution is dismissed for good cause in accordance with 28 Texas Administrative Code §133.307(f)(3)(D).

DISMISSAL

The Division has determined that the requestor does not have the right to file for medical fee dispute resolution. The request for medical fee dispute resolution is hereby dismissed.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 10, 2015 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, 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 MFDR 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.