



**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**

EAST TEXAS ANESTHESIOLOGY ASSOCIATES  
4100 INTERNATIONAL PLAZA STE 600  
FORT WORTH TX 76109

**Respondent Name**

SERVICE LLOYDS INSURANCE CO

**MFDR Tracking Number**

M4-15-4181-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

AUGUST 26, 2015

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "This claim was denied for timely filing. We originally filed this claim to the employer [employer name] as per the face sheet we obtained from the facility. We tried to call the employer. We obtained the correct WC insurance address and faxed the claim on 040415..."

**Amount in Dispute:** \$920.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The requestor, East Texas Anesthesiology Associates indicated in the evidence submitted in the medical fee dispute request that the medical billing in question was originally billed to the injured employee's employer. Pursuant to division rules referenced herein a health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to: prompt payment, interest for delayed payment and medical fee dispute resolution."

**Response Submitted by:** CorVel Healthcare Corporation

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 1, 2014	Anesthesiology Services	\$920.00	\$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.
- 28 Texas Administrative Code §133.20 sets out the health care provider billing procedures.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 29 – Time limit for filing claim/bill has expired.
  - W3 – Appeal/Reconsideration

**Issues**

- 1. Did the requestor bill the employer?
- 2. Is the requestor entitled to reimbursement?

**Findings**

- 1. Review of the documentation submitted by the healthcare provider finds that the requestor initially billed the employer.
- 2. In accordance with 28 Texas Administrative Code §133.20(j)(1) a health care provider who elects to submit medical bills to an employer waives, for the duration of the election period, the rights to: (A) prompt payment, as provided by Labor Code §408.027; (B) interest for delayed payment as provided by Labor Code §413.019; and (C) medical dispute resolution as provided by Labor Code §413.031. Therefore, the healthcare provider is not entitled to reimbursement for these services.

**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**

Signature	Medical Fee Dispute Resolution Officer	September 25, 2015 Date
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**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.**