TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DOUGLAS BURKE DC

Respondent Name
INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-18-0972-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
December 7, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: $2,615.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In this case, there has not been a final adjudication of the extent of injury, and this medical fee dispute resolution is premature. In conclusion, Requestor has treated conditions not accepted as part of the compensable injury and is not entitled to reimbursement."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2014 through November 14, 2014	97110, 97140 and 97750-FC	$2,615.00	$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.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes: Explanation of Benefits
   - 219 – Based on extent of injury
   - 216 – Based on the findings of a review organization

Issues

1. Did the requestor waive the right to medical fee dispute resolution?
2. Does the dispute contain unresolved extent of injury issues?

Findings

1. The requestor seeks reimbursement for dates of service September 10, 2014, October 15, 2014 and October 29, 2014. 28 Texas Administrative Code §133.307(c) (1) states in pertinent part, "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 dates of the service in dispute are September 10, 2014, October 15, 2014 and October 29, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on December 7, 2017. 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 for dates of service September 10, 2014, October 15, 2014 and October 29, 2014.

2. The requestor seeks reimbursement for dates of service October 8, 2014, October 22, 2014, October 23, 2014, November 13, 2014 and November 14, 2014. The insurance carrier denied the disputed dates of service with denial reduction codes, "219 – Based on extent of injury" and "216 – Based on the findings of a review organization."

   28 Texas Administrative Code §133.305(b) states that if a dispute regarding extent of injury exists for the same service for which there is a medical fee dispute, the dispute regarding extent of injury shall be resolved prior to the submission of a medical fee dispute.

   Documentation provided by the parties indicates that the insurance carrier denied payment to the requestor due to an unresolved extent of injury issue. The carrier's explanation of benefits was timely presented to the requestor in the manner required by 28 Texas Administrative Code §133.240.

   The service in dispute contains an unresolved extent of injury issue. For that reason, this matter is not eligible for adjudication of a medical fee under 28 Texas Administrative Code §133.307.

   The Division hereby notifies the requestor that the appropriate process to resolve the extent of injury issue is found a Texas Labor Code, Chapter 410, and corresponding 28 Texas Administrative Code §141.1. The requestor may choose to file the required DWC Form-045 titled *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference (BRC)* to resolve this matter. A copy of the form and corresponding instructions are attached

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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

		January 12, 2018
Signature	Medical Fee Dispute Resolution Officer	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 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.