TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Patient Care Injury Clinic

Respondent Name
Worth Casualty Co

MFDR Tracking Number
M4-18-4133-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
June 26, 2018

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 20 – 23, 2017	Physical Therapy Services	$622.58	$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 health care providers to pursue a medical fee dispute.
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

Issue

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

Findings

1. Review of the submitted Medical Fee Dispute Request finds the date of service is January 20 - 2017. This is outside the one year requirement. The Division's Bulletin # B-0020-17 states in pertinent part,

   "For system participants who reside in the counties listed in the Governor's disaster proclamation, the Texas workers' compensation deadlines for the following procedures are tolled through the duration of the Governor's disaster proclamation:
   - Workers' compensation claim notification and filing deadlines.
   - Medical billing deadlines.
   - Medical and income benefit payment deadlines
   - Electronic date reporting deadlines, and
   - Medical and income benefit dispute deadlines

Review of the submitted medical bill found the zip code of 77076 in Harris County which is a county covered by the proclamation. The tolled period, or time not counted towards the one year submission of the MFDR request is as follows. The date of service is January 20 – 23, 2017. From this date until the date of proclamation B-0020-17 (August 23, 2017) is 212 days. Counting stopped on this date.

Beginning on January 10, 2018 via proclamation B-0042-17, counting began again. The time period from January 10, 2018 until the date the request for MFDR was received or June 26, 2018 is 167 days. The total days is 379 (212 + 167). This exceeds the one year (365 days) timeliness requirement shown below.

28 Texas Administrative Code §133.307(c)(1)(A) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (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 Division concludes that the requestor has failed to timely file this dispute with the Division's MDR 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. For that reason, the merits of the issues raised by both 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 disputed services.

Authorized Signature

		August 14, 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 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.