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
MEMORIAL MRI & DIAGNOSTIC

Respondent Name
PENNSYLVANIA MANUFACTURERS ASSOCIATION INSURANCE COMPANY

MFDR Tracking Number
M4-18-4418-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 20, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I faxed and certified mail my corrected claim. . . .I received a letter from MedRisk stating they could not process bill because it was not handled by them and to submit bills directly to the insurance carrier for payment."

Amount in Dispute: $2,625.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: None

Response Submitted by: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Dispute Amount	Amount Due
February 19, 2018	Professional Medical Services	$2,625.00	$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. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §133.20 sets out requirements for health care providers submitting medical bills.
4. The division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, receipt acknowledged July 30, 2018. 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 has not responded. Accordingly, this decision is based on the information available at the time of review.
5. No explanations of benefits were presented for review by either party to this dispute.
6. The provider presented copies of claim rejection letters from MedRisk advising that "medical services not handled by MedRisk. Please submit bills directly to the insurance carrier for payment."

Issues

1. Did the health care provider submit the claims to the insurance carrier for payment?

Findings

1. 28 Texas Administrative Code §133.20(a) requires that "the health care provider shall submit all medical bills to the insurance carrier except when billing the employer in accordance with subsection (j)"

   The health care provider asserts and provided documentation to support that medical bills were sent to MedRisk, at an address in Lexington, Kentucky. MedRisk is a medical network and provider of managed physical medicine services; MedRisk is not an insurance carrier. Nor was any information presented to support that MedRisk is an insurance carrier or an agent of the insurance carrier responsible for the disputed services.

   Based on information maintained by the division, the insurance carrier for the disputed injury is Pennsylvania Manufacturers Association Insurance Company, with mailing address listed as PO Box 141659, Irving, TX 75014.

   The requestor provided copies of two bill rejection letters from MedRisk advising "medical services not handled by MedRisk. Please submit bills directly to the insurance carrier for payment."

   No information was provided to support that the medical bill was ever sent to the correct insurance carrier.

   Accordingly, the division concludes that the health care provider failed to meet the requirements of Rule §133.20(a) requiring the health care provider to submit the medical bill to the insurance carrier for payment.

   Because the health care provider has not submitted the bill to the correct insurance carrier for consideration, this medical fee dispute is not eligible for review.

Conclusion

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though not all the evidence was discussed, it was considered.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	October 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 Rule §133.307.

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 form's instructions. 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 on the form, or to the field office handling the claim.

A party seeking review of this decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. The request must include a copy of this *Medical Fee Dispute 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.