



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

FRANCES BURCH MD

Respondent Name

SAN ANTONIO ISD

MFDR Tracking Number

M4-19-4159-01

Carrier's Austin Representative

Box Number 21

MFDR Date Received

May 17, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Frances Burch submitted claims for dates of service 9/27/16 to 8/22/17, which have yet to be paid. These claims were never paid because the initial Carrier, TriStar, claims they never received them therefore could not forward them to Claims Administration when they took over TriStar's claims."

Amount in Dispute: \$1,410.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Deadline for filing a Medical Dispute Resolution is no later than one year after the date(s) of service in dispute. Based on the date of service of 1/11/17 - 8/22/17 the time to file a Medical Dispute Resolution has expired. We ask that the MDR be withdrawn due the expiration date."

Response Submitted by: IMO

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: September 27, 2016 through August 22, 2017, 99213 x 8 and 99455-V5 x 2, \$1,410.00, \$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. Neither the requestor nor the respondent submitted copies of EOBs with the DWCO60 request.

Issues

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

Findings

1. The requestor seeks reimbursement for medical services rendered on September 27, 2016 through August 22, 2017. 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 services in dispute are September 27, 2016 through August 22, 2017. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on May 17, 2019. 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.

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

| | | |
|-----------|--|---------------|
| | | June 14, 2019 |
| 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.