



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

DOUGLAS BURKE DC

Respondent Name

SAN ANTONIO ISD

MFDR Tracking Number

M4-19-4669-01

Carrier's Austin Representative

Box Number 21

MFDR Date Received

June 25, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Douglas Burke submitted claims for date of service 7/24/2017, 7/25/2017, 7/26/2017, and 12/5/2017, which have yet to be paid. These dates of service fall within the transition of Carrier's between TriStar and Claims Administration/IMO... During the time TriStar was managing claims for SAISD employees, it looks as though some bills were not forwarded to IMO. Dr. Burke did not submit bills directly to IMO because he was under the impression the bills would be forwarded internally so if IMO shows that they did not receive the bills until 12/05/2018 then that means the bills were forwarded late by the previous Carrier. I ask that you please review the attached documentation and recommend payment for all 4 dates of service. I do not feel Dr. Burke's bills should be denied when he performed a service to his patient and billed within the timely filing period and the bills seem to have been lost in transition of the two Carriers."

Amount in Dispute: \$900.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are requesting the Division dismiss the Medical Dispute Request to these dates of service because the requestor did not file timely. See Division Rule 133.3079c) [sic] (Request for medical fee dispute resolution must be filed 'no later than one year after the date(s) of service in dispute.')

Response Submitted by: IMO

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 24, 2017 through December 5, 2017, 97710-GP x 4 and 97140-GP-59 x 4, \$900.00, \$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.

**Issues**

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

**Findings**

- 1. The requestor seeks reimbursement for medical services rendered on July 24, 2017 through December 5, 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 July 24, 2017 through December 5, 2017. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on June 25, 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
July 18, 2019  
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.**