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
Prime Diagnostic Imaging

Respondent Name
Great American Alliance Insurance Co

MFDR Tracking Number
M4-20-0606-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The MRI was denied at the time of service."

Amount in Dispute: $3,022.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please note that the date of service is May 16, 2018 yet the provider did not file its DWC-60 until November 4, 2019, which is well outside of the one year deadline following the ate of service."

Response Submitted by: Flahive, Ogden and Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2018	72148	$3,022.00	$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

28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

Was the request for Medical Fee Dispute resolution submitted timely?

Findings

The requestor is seeking reimbursement of professional medical services rendered on May 16, 2018. The request for MFDR was received November 4, 2019.

28 TAC §133.307 (c)(1) states a requestor a request for MFDR that does not involve issues of compensability, extent of injury, or liability shall be filed no later than one year after the date(s) of service in dispute.

Review of the submitted documentation found insufficient evidence to support an exception to the timely filing requirement of MFDR.

Based on the above, this request for medical fee dispute is not eligible for review.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment 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

		December 20, 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 Rule §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 DWC on within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to DWC 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. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.