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
Allen Orthotics & Prosthetics

Respondent Name
Chubb Indemnity Insurance Co

MFDR Tracking Number
M4-21-0106-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
September 24, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have provided services on two different occasions from this company and have yet to be reimbursed appropriately. All services were approved before providing them yet the carrier is refusing to process these claims."

Amount in Dispute: $985.48

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel asserts the requestor Allen Orthotics & Prosthetics is entitled to $0.00 reimbursement for durable medical equipment in dispute based on the requestor's failure to request medical ree dispute resolution no later than one year after the date of service in dispute."

Response Submitted by: CorVel Healthcare Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 27, 2019 June 12, 2019	A6549 A6504	$985.48	$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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payment adjusted/unsupported service level

Issue

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

Findings

1. The requestor is seeking reimbursement of medical services rendered in February and June 2019. The insurance carrier denied as level of service not supported.

   28 TAC §133.307(c)(1) states unless an issue of compensability, extent of injury, liability, medical necessity or a refund exists the request for MFDR must be filed no later than one yar after the date of service.

   The dates of the service in dispute is February 27, 2019 and June 12, 2019. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on September 24, 2020.

   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 above.

   DWC concludes that the requestor has failed to timely file this dispute with DWC's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

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 upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, DWC has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		October 19, 2020
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 TAC §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 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 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 DWC. **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.