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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MIGUEL HERNANDEZ MD

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-07-3675-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
FEBRUARY 5, 2007

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Ins. Carrier states we did not file claims on timely basis, the fact is they were, see our letter of appeals. Claims have the date on bottom left hand corner, yet Ins. Carrier refuses payment."

Amount in Dispute: $795.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a Mississippi workers compensation claim. A copy of the Mississippi First Report of Injury is attached. As such, the Division has no jurisdiction over this dispute, and it should be dismissed in accordance with Rule 133.307(e)(3)(J)."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 29, 2006	CPT Code 97110-GP (X4)	$240.00	$0.00
July 5, 2006 July 6, 2006 July 7, 2006	CPT Code 97110-GP (X3)	$180.00/each	$0.00
September 19, 2006	CPT Code 99080-73	$15.00	$0.00
TOTAL		$795.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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. Texas Labor Code §406.075, effective September 1, 1993, prohibits claims from other workers compensation jurisdictions from seeking benefit in the Texas Workers Compensation.

Issues

Does Medical Fee Dispute Resolution have jurisdiction to review this dispute?

Findings

On February 5, 2007, the requestor, Miguel Hernandez, MD, sought medical fee dispute resolution under 28 Texas Administrative Code §133.307. The requestor is seeking reimbursement of $795.00 for physical therapy services and report rendered on June 29, 2006 through September 19, 2006.

The respondent's representative, William E. Weldon. submitted a response to this request for medical fee dispute resolution on June 4, 2012. The respondent stated "This is a Mississippi workers compensation claim." In support of their position, a copy of the MWCC-Workers' Compensation-First Report of Injury or Illness report supports the respondent's position that this is a Mississippi Workers' Compensation claim.

Texas Labor Code §406.075(a) states "An injured employee who elects to pursue the employee 's remedy under the workers ' compensation laws of another jurisdiction and who recovers benefits under those laws may not recover under this subtitle." Because the claimant pursued remedy under Mississippi's Workers' Compensation, the requestor is prohibited from seeking recovery under the Texas Workers Compensation per Texas Labor Code §406.075(a). As a result, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division cannot recommend reimbursement.

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

Elizabeth Pickle
Signature

Elizabeth Pickle, RHIA
Medical Fee Dispute Resolution Officer

05/12/2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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