Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PROVIDENCE MEMORIAL HOSPITAL
PO BOX 849763
DALLAS TX 75284-9770

Carrier's Austin Representative Box
53

Respondent Name
UNITED STATES FIRE INSURANCE

MFDR Date Received
APRIL 3, 2007

MFDR Tracking Number
M4-07-4820-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Stoploss reim at 75% Implants Cost + 10%."

Amount in Dispute: $108,223.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary Dated April 23, 2007: "As a result of the review, carrier maintains that proper jurisdiction for this claim should be in the state of New Mexico. This claim is currently being handled under New Mexico Workers' Compensation file number [redacted]

Respondent's Supplemental Position Summary Dated August 9, 2007: "I am filing the DWC-60 Form on behalf of the above-referenced insurance carrier in response to the Requestor's dispute for fee reimbursement for the date of service on 05/19/06-05/21/06. As a result of the review, please see the EOB's showing payment made in the amounts of $25,863.39 and a subsequent payment made on 6-14-07 for $63,169.00."

Respondent's Supplemental Position Summary Dated February 11, 2014: "This is a New Mexico claim in which payment was made under New Mexico's work comp."

Responses Submitted by: Hoffman Kelley, L.L.P.

SUMMARY OF FINDINGS

Disputed Dates	Disputed Services	Amount In Dispute	Amount Due
May 19, 2006 through May 21, 2006	Inpatient Hospital Services	$108,223.13	$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

Is the requestor entitled to additional reimbursement?

Findings

On April 3, 2007, the requestor, Providence Memorial Hospital, sought medical fee dispute resolution under 28 Texas Administrative Code §133.307. The requestor is seeking additional reimbursement of $108,223.13 for inpatient hospitalization services rendered on May 19, 2006 through May 21, 2006.

The respondent's representative, Hoffman Kelley, L.L.P. submitted a response to this request for medical fee dispute resolution on April 23, 2007. The respondent stated "proper jurisdiction for this claim should be in the state of New Mexico. This claim is currently being handled under New Mexico Workers' Compensation file number [redacted] In support of their position, a copy of the Workers Compensation and Employers' Liability Insurance Policy report supports the respondent's position that this is a New Mexico 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 New Mexico'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.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/25/2014 Date
Signature	Healthcare Business Management Director	02/25/2014 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.