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 and Address

DR SUHAIL AL-SAHLI
1210A NASA RD 1
HOUSTON TX 77058

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-08-2297-01

MFDR Date Received

APRIL 22, 2005

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "COMPENSABLE INJURY."

Amount in Dispute: $10,887.56

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This carrier is disputing the injured worker's claim in entirely. Exhibit 2. It is this carrier's position Medical Dispute Resolution has no jurisdiction to proceed with dispute resolution. TWCC Rule 133.305(a)(1) defined the circumstances under which medical dispute resolution may be requested and denial for compensability is not one of the circumstances."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 13, 2004 through December 13, 2004	Professional Services CPT Codes 98940, 97110, 97124, 99212, 99213, 98941, 97012, 97116, 97112, 97140	$10,887.56	$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 §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. EOBs submitted with the requestor's dispute indicate the respondent has raised issues of Compensability, Extent, and/or Liability .

Issues

1. Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code

§133.305 and §133.307?

2. Is the requestor eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The requestor filed a dispute with the Medical Fee Dispute Resolution section at the Division on April 22, 2005. According to 28 Texas Administrative Code §133.305(a)(2), "Medical Fee Disputes--Medical Fee Disputes involve a dispute over the amount of payment for health care rendered to an injured employee and determined to be medically necessary and appropriate for treatment of that employee's compensable injury. The dispute is for reasons other than the medical necessity of the care (e.g. based upon the requirements of commission rules or fee guidelines). The dispute is resolved by the commission pursuant to commission rules, including §133.307 of this title (relating to Medical Dispute Resolution of a Medical Fee Dispute)."

   28 Texas Administrative Code §133.305(e)(2)(D) goes on to state that "if the carrier has raised a dispute pertaining to liability for the claim, compensability, or extent of injury, in accordance with §124.2 of this title (relating to Carrier Reporting and Notification Requirements), the request for an IRO will be held in abeyance until those disputes have been resolved by a final decision of the commission."

   The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved as of the undersigned date.
2. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

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 services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	02/28/2014 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.