



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

Allied Medical Centers

Respondent Name

INDEMNITY INSURANCE CO

MFDR Tracking Number

M4-10-4889-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

July 26, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has sent a status request and a request for reconsideration, all of which have not been replied to. Therefore does not give us an avenue to properly seek reimbursement for services we provided."

Amount in Dispute: \$75.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "309.81-PTSD is not a part of the 'agreed' compensable injury see attached DWC24. Denied for extent see DWC 24."

Response Submitted by: Strain Law Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 5, 2009	99212 and 99080	\$75.00	\$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

- 28 Texas Administrative Code §133.305 relates to MDR – General.
- 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
- Neither the requestor nor the respondent submitted copies of EOBs with the dispute request/response.

Issues

- Did the requestor file for medical fee dispute resolution in accordance with 28 Texas Administrative Code §§133.305 and 133.307?
- 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. According to 28 Texas Administrative Code §133.305(a)(4), a medical fee dispute is a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) for health care determined to be medically necessary and appropriate for treatment of that employee’s compensable injury.

28 Texas Administrative Code §133.305(b) goes on to state, “Dispute Sequence. If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021”.

28 Texas Administrative Code §133.307(e) (3) (H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals. 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.

No documentation was found 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 services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement 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, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

May 15, 2014

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.