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
DR AJAY BINDAL

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-11-0999-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
NOVEMBER 22, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Baccom assessment was also spondylolisthesis as was Dr. Bindal's not sprain & strain. Also the radiology report stated spondylolisthesis. The claim should be pd because spondylolisthesis should be the compensable injury."

Amount in Dispute: $239.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor's request for medical fee dispute resolution does not meet the filing requirements of DWC Rule 133.307."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 29, 2010	Office Visit CPT Code 99204	$239.00	$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 effective May 25, 2008, 33 Texas Register 3954, applicable to requests filed on or after May 25, 2008 sets out the procedures for resolving medical fee disputes.
2. Neither party to the dispute submitted copies of explanation of benefits to support the denial/reduction of payment for the disputed services.

Issues

1. Was the dispute filed in the form and manner required by 28 Texas Administrative Code §133.307? Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(2)(A) requires that the request shall include "a copy of all medical bill(s)… as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration…" Review of the documentation submitted by the requestor finds that the requestor has not provided a copy of the medical bill(s) as originally submitted to the carrier and/or as submitted for reconsideration. The Division concludes that the requestor has not met the requirements of 28 Texas Administrative Code §133.307(c)(2)(A).

   28 Texas Administrative Code §133.307(c)(2)(B) requires that the request shall include "a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB." Review of the submitted documentation finds that the requestor has not provided a copy of the EOB detailing the insurance carrier's response to the request for reconsideration. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of 28 Texas Administrative Code §133.307(c)(2)(B).

   28 Texas Administrative Code §133.307(c)(2)(E) requires that the request shall include "a copy of all applicable medical records specific to the dates of service in dispute." Review of the documentation submitted by the requestor finds that the requestor has not provided medical records to support the services in dispute. The Division concludes that requestor has not met the requirements of 28 Texas Administrative Code §133.307(c)(2)(E).

   The Division concludes that the requestor has failed to submit this dispute in the form and manner required by 28 Texas Administrative Code §133.307. Furthermore, the requestor failed to submit documentation to support billed service. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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	04/30/2014 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.