



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

Grant McKeever, M.D.

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-11-1569

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

January 18, 2011

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We seek full reimbursement for the outstanding balance of \$800.00 ..."

**Amount in Dispute:** \$800.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "A Designate Doctor (DD) determined MMI and IR on 8/24/09. The findings were not disputed by the treating doctor or the claimant."

**Response Submitted by:** Texas Mutual Insurance Company

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 28, 2010	Examination by a Referral Doctor to Determine Maximum Medical Improvement and Impairment Rating	\$800.00	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.305 sets forth general procedures regarding the dispute of medical bills.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §141.1 provides the procedures for requesting and setting a Benefit Review Conference.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - CAC-B22 – This payment is adjusted based on the diagnosis.
  - CAC-W1 – Workers Compensation state fee schedule adjustment.

- 743 – MMI/IR has been determined by a Designated Doctor. Subsequent exams for MMI/IR not appropriate.
- 907 – Only treatment rendered for the compensable injury is reimbursable. Not all conditions indicated are related to the compensable injury.
- CAC-W4 – No additional payment allowed after review of appeal/reconsideration.
- 724 – No additional payment after a reconsideration of services.

### **Issues**

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

### **Findings**

1. 28 Texas Administrative Code §133.305(a)(4), effective May 25, 2008, 33 TexReg 3954, defines a medical fee dispute as "... a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury..." 28 Texas Administrative Code §133.305(b), effective May 25, 2008, 33 TexReg 3954, requires that

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), effective May 25, 2008, 33 TexReg 3954, 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 28 Texas Administrative Code §124.2 of this title. The appropriate dispute process to resolve issues of compensability, extent of injury and/or liability requires the filing of a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. The division will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals.

Review of the submitted documentation finds that there are unresolved issues of extent of injury for the same services for which there is a medical fee dispute. No documentation was submitted to support that the issues of extent of injury were resolved prior to the filing of the request for medical fee dispute resolution.

2. The Division finds that 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 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

Laurie Garnes  
\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

December 4, 2015  
\_\_\_\_\_  
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 MFDR 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 this *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.**