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
SOUTH TEXAS HEALTH SYSTEM

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-11-2559

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 28, 2011

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 30, 2010 to August 2, 2010	Hospital Services	$3,000.81	$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.

Issues

1. Does MFDR have jurisdiction to review this dispute?

Findings

1. 28 Texas Administrative Code §133.307(a)(3) requires that "In resolving non-network disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the Division of Workers' Compensation (Division) is to adjudicate the payment, given the relevant statutory provisions and Division rules." Review of Division records and the submitted information finds that the injured employee does not have an existing claim for benefits under the Texas workers' compensation system. Rather, the Division has good cause to believe that the disputed health care relates to the injured employee's claim for benefits under the workers' compensation laws of the state of Louisiana. Consequently, Medical Fee Dispute Resolution (MFDR) does not have jurisdiction to consider the dispute. The Division therefore concludes that this dispute is not eligible for review.

Conclusion

MFDR does not have jurisdiction to review this dispute. The dispute is hereby dismissed for good cause in accordance with 28 Texas Administrative Code §133.307(e)(3)(J). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

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 it does not have jurisdiction over this dispute. The request for medical fee dispute resolution is hereby dismissed.

Authorized Signature

	Grayson Richardson	February 27, 2015
Signature	Medical Fee Dispute Resolution Officer	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.