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
CURNYN PHYSICAL THERAPY

MFDR Tracking Number
M4-11-3038-02

MFDR Date Received
May 9, 2011

Respondent Name
LIBERTY MUTUAL INSURANCE CORP

Carrier's Austin Representative
Box Number 01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review."

Amount in Dispute: $1,665.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Pre-authorization was requested but denied for this service per DWC Rule 134.600."

Response Submitted by: Liberty Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
June 9, 2010 through July 13, 2010	97001, 97010, 97032 and 97530	$1,665.00	$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 sets out the procedures for resolving medical fee disputes.
2. Neither party presented EOBs for consideration in this review.

Issues

1. Did the requestor submit copies of the EOBs with the DWC060 request?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Codes 97001, 97010, 97032 and 97530 rendered on June 9, 2010 through July 13, 2010.

   28 Texas Administrative Code §133.307 (c)(2)(K) states in pertinent part, "Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include. (K) a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB."

   Former 28 Texas Administrative Code §133.307(c)(2)(B), effective May 25, 2008, 33 *Texas Register* 3954, requires that the request shall include "a copy of each explanation of benefits (EOB) . . . 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 request does not include copies of any EOBs for the disputed services. 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 §133.307(c)(2)(B).

   Former 28 Texas Administrative Code §133.307(c)(2)(C), effective May 25, 2008, 33 *Texas Register* 3954, requires that the request shall include "the form DWC-60 table listing the specific disputed... charges in the form and manner prescribed by the Division." Review of the submitted documentation finds that the requestor has not completed the form DWC-60 table listing the specific disputed charges in the form and manner prescribed by the Division. The requestor has therefore failed to complete the required sections of the request in the form and manner prescribed under §133.307(c)(2)(C).

   Former 28 Texas Administrative Code §133.307(c)(2)(F)(i), effective May 25, 2008, 33 *Texas Register* 3954, requires that the request shall include a position statement including "a description of the health care for which payment is in dispute." Review of the submitted documentation finds that the requestor has not provided a description of the health care for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(i).

   Former 28 Texas Administrative Code §133.307(c)(2)(F)(ii), effective May 25, 2008, 33 *Texas Register* 3954, requires that the request shall include a position statement including "the requestor's reasoning for why the disputed fees should be paid or refunded." Review of the submitted documentation finds that the requestor has not explained the reasons that the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(ii).

   Former 28 Texas Administrative Code §133.307(c)(2)(F)(iii), effective May 25, 2008, 33 *Texas Register* 3954, requires that the request shall include a position statement of the disputed issues including "how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iii).

   Former 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective May 25, 2008, 33 *Texas Register* 3954, requires that the request shall include a position statement of the disputed issues including "how the submitted documentation supports the requestor position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).

2. Review of the submitted documentation finds that the requestor has not established that reimbursement is due for the disputed services. As a result, $0.00 is recommended.

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

		May 9, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** form (**DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.