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
KINETIC CLINIC

Respondent Name
FREESTONE INSURANCE CO

MFDR Tracking Number
M4-11-3647-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JUNE 20, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Received EOB'S from insurance company with denied payment due to diagnosis Bills resubmitted on 04/13/11 with Designated Doctor report accepting the following diagnosis:

1. head laceration
2. post concussive syndrome, causing blurred vision
3. cervical sprain/strain"

Amount in Dispute: $947.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The subject of this dispute involves payment for chiropractic services. The requestor is seeking $947 in reimbursement for the treatment. As a basis, the Requestor is asserting that the Designated Doctor included the disputed body parts as a part of the compensable injury. However, the bodies parts are not part of the acceptable "

Response Submitted by: Lewis & Backhaus,PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 14, 2010	CPT Code 99204	$167.00	$0.00
September 14, 2010 October 12, 2010 November 9, 2010 December 8, 2010 January 12, 2011	CPT Code 99080	$15.00/each	$0.00
September 14, 2010	HCPCS Code E0215	$80.00	$0.00
October 12, 2010 November 9, 2010 December 8, 2010 January 12, 2011 March 14, 2011	CPT Code 99214	$106.00/each	$0.00

October 29, 2010	CPT Code 95831	$45.00	$0.00
October 29, 2010	CPT Code 95851	$35.00	$0.00
TOTAL		$947.00	$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 §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. EOBs submitted with the requestor's dispute indicate the respondent has raised issues of Compensability, Extent, and/or Liability.

Issues

1. Does a compensability, extent, and/or liability issue exist in this dispute?
2. Is the dispute eligible for medical fee dispute resolution?

Findings

1. According to 28 Texas Administrative Code §133.305(a)(4), 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) goes on to state 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) 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 prior to requesting medical fee dispute resolution. No documentation was submitted 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 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

		05/08/2014
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.