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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GLENN J. BRICKEN, MD

Respondent Name
NEW HAMPSHIRE INSURANCE COMPANY

MFDR Tracking Number
M4-11-3663-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 23, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the dates of service for 'non-covered charges.' The HCP is confused about this denial rationale because it is not specific."

Amount in Dispute: $1,134.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The treatment was for non-compensable diagnosis . . . I have attached a DWC24 signed by all parties along with the PLN11 dated 7/30/2009."

Response Submitted by: Chartis Claim Services, Dallas Worker's Compensation Service Center

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 29, 2010 to October 21, 2010	Procedure Code 90806	$1,134.00	$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

1. 28 Texas Administrative Code §124.2 sets out requirements for carrier reporting and notification.
2. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §141.1 sets out the procedures for requesting a benefit review conference.
5. Texas Labor Code §408.021 sets out provisions regarding entitlement to medical benefits.
6. Texas Labor Code §413.031 sets out provisions regarding medical dispute resolution.

7. The insurance carrier denied payment for the disputed services with the following claim adjustment codes:
   - 96 – Non-covered charge(s).
   - X347 – The service(s) is for a condition(s) which is not related to the covered work related injury.
   - 11 – The diagnosis is inconsistent with the procedure.
   - 51 – These are non-covered services because this is a pre-existing condition.

Issues

1. Are there unresolved issues of compensability, extent of injury, or liability regarding the services in dispute?
2. Can the Division adjudicate the medical fee issues in this dispute?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) 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) 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) 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 of injury, or liability requires the health care provider to submit a request for a benefit review conference pursuant to 28 Texas Administrative Code §141.1. All outstanding issues regarding compensability, extent of injury, or liability for the disputed services must be resolved before requesting medical fee dispute resolution.

   Review of the submitted documentation finds that there are unresolved issues of compensability, extent of injury, or liability for the same service(s) for which there is a medical fee dispute. No documentation was presented to support that the issue(s) of compensability, extent of injury, or liability have been resolved.

2. The requestor has failed to support that the outstanding issues regarding compensability, extent of injury or liability for the disputed services have been resolved. Consequently, the Division cannot consider the medical fee issues in dispute. This dispute is dismissed until all outstanding issues of compensability, extent of injury, or liability concerning the disputed services have been resolved by a final decision, inclusive of all appeals.

Conclusion

For the reasons stated above, the requestor has failed to establish that the outstanding issues concerning compensability, extent of injury, or liability for the injured employee's workers' compensation claim with respect to the disputed medical services have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 before submitting a request for medical fee dispute resolution regarding the same services. Consequently, the Division's Medical Fee Dispute Resolution section does not have authority to review the disputed medical fee issues. As a result, no additional payment can be ordered.

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 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	July 29, 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 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.