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
EDWIN E. JOHNSTONE, MD

Respondent Name
COMMERCE & INDUSTRY INSURANCE

MFDR Tracking Number
M4-11-4317-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JULY 21, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As you can read AIG was negotiating a settlement with this patient but why should we be denied payment, they did not include us in the negotiations so we would have no way to know. Between her first visit of April 11, 2011 and her last visit on May 10, 2011 the case was settled."

Amount in Dispute: $165.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to the request for Medical Fee Dispute Resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 10, 2011	CPT Code 99214 Office Visit	$150.00	$0.00
	CPT Code 99080-73 Work Status Report	$15.00	$0.00
TOTAL		$165.00	$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 §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §417.002 outlines the process for recovery in third-party settlements.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - X336-Case has been settled; therefore payment is denied.

- X731-Denied per Adjuster.
- X395-This bill was paid according to fee schedule/usual and customary guidelines. No additional payment is recommended.

4. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on August 3, 2011. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

Is the insurance carrier's reason for denial of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code "336."

Texas Labor Code §417.002(a-c), RECOVERY IN THIRD-PARTY ACTION states,

> The net amount recovered by a claimant in a third-party action shall be used to reimburse the insurance carrier for benefits, including medical benefits, that have been paid for the compensable injury. (b) Any amount recovered that exceeds the amount of the reimbursement required under Subsection (a) shall be treated as an advance against future benefits, including medical benefits, that the claimant is entitled to receive under this subtitle. (c) If the advance under Subsection (b) is adequate to cover all future benefits, the insurance carrier is not required to resume the payment of benefits. If the advance is insufficient, the insurance carrier shall resume the payment of benefits when the advance is exhausted.

The Division reviewed the submitted documentation and finds:

5. No documentation was submitted to refute the explanation of benefits/carrier's position that the service in dispute are subject to payment from a third-party settlement; and
6. No documentation was found to support that the net amount recovered in the settlement was exhausted.

The Division concludes 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 reimbursement is due. As a result, the amount ordered is $0.00. The Division emphasized that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. Even though all the evidence was not discussed, it was considered.

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

		07/23/2015
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.