



**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](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name and Address**

INJURY REHAB CLINIC

**Respondent's Name**

METROPOLITAN TRANSIT AUTHORITY

**MFDR Tracking Number**

M4-11-4496-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

August 1, 2011

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "...I am not clear as to why these claim(s) remain unpaid and also I believe the patient is not getting the care that she deserves based on the fact of her past injuries that has been stated by the adjuster is the reason they are not paying for services other than a lumbar strain."

**Amount in Dispute:** \$1,596.39

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "A review of the EOB's included with the requestor's request for medical dispute resolution clearly outlines the self-insured's position regarding the disputed charges. Specifically, the self-insured notes it has only accepted a lumbar sprain/strain injury per a February 2011 benefit dispute agreement. No other body parts or conditions are considered compensable at this time. The self-insured submits that the medical treatment underlying the disputed charges was offered for body parts/conditions beyond the accepted lumbar sprain/strain injury."

**Response Submitted by:** Flahive, Ogden & Latson

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 9, 2011 through May 19, 2011	98940, 97110, 99080, 99214 and 99202	\$1,596.39	\$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**

- 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
- This request for medical fee dispute resolution was received by the Division on August 1, 2011.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 150 – Payment adjusted because the payer deems the information submitted does not support this level of service.
- 185 – The rendering provider is not eligible to perform the service billed.
- 193 – Original payment decision is being maintained. The claim was processed properly the first time.
- 219 – Based on extent of injury.
- 150 – Per Medicare Therapy Services, documentation of each treatment shall include identification of each specific intervention/modality provided and billed, for both times and untimed codes.
- 219 – Metropolitan Transit Authority defines the compensable injury as limited to a lumbar strain/sprain per the Benefit Dispute Agreement on 02/03/2011.

**Issues**

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

**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 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.

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

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 requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is 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 reimbursement for the services in dispute.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

June 23, 2014

***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.**