Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CCSR INC.
PO BOX 700311
SAN ANTONIO, TX 78207

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Respondent Name
WAL MART ASSOCIATES INC

Carrier's Austin Representative Box
Box Number 53

MFDR Tracking Number
M4-11-4835-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medical Necessity established IRO approved CPMP."

Amount in Dispute: $520.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The denial was based upon a physician retrospective review and would be subject to an Independent Review Organization Per Rule 133.305(10): "Retrospective medical necessity dispute—A dispute that involves a review of the medical necessity of health care already provided. The dispute is reviewed by an IRO pursuant to the Insurance Code, Labor code and related rules, including §133.308 of this subchapter." These services are not subject to medical dispute resolution of fee disputes."

Response Submitted by: Hoffman Kelley Attorneys At Law 5316 Hwy 290 West Suite 360

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 29, 2011	97750	$ 520.00	$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 medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent

Review Organization (IRO).

4. This request for medical fee dispute resolution was received by the Division on July 21, 2011.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 4, 2011 and May 31, 2011
   - 50 –THESE ARE NON-COVERED SERVICES BECAUSE THIS IS NOT DEEMED A 'MEDICAL NECESSITY' BY THE PAYER
   - 5059 –BASED ON THE DIAGNOSIS TREATMENT PATTERNS AND/OR NUMBER OF VISITS, THE TREATMENT EXCEEDS OUR PHYSICIAN PARAMETERS, REFER TO DOCTOR REPORT
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME
   - 5081 –REDUCTION OR DENIAL OF PAYMENT RESULTIN AFTER A RECONSIDERATION WAS COMPLETED

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) for health care 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)(G) requires that if the request contains an unresolved adverse determination of medical necessity, the Division shall notify the parties of the review requirements pursuant to §133.308 of this subchapter (relating to MDR by Independent Review Organizations) and will dismiss the request in accordance with the process outlined in §133.305 of this subchapter (relating to MDR--General). The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity for the service in dispute.
2. Injured employee was referred by treating doctor for Physical Performance Evaluation. Insurance Carrier denied medical necessity, for service in dispute, based on physician retrospective review (not included in documentation submitted). No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution.
3. The requestor has failed to support that the 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 medical necessity have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 413 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

Laura Campbell	Laura Campbell	January 31, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it 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.