



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
MAKE TODAY COUNT INC

Respondent Name
TX PUBLIC SCHOOL WC PROJECT

MFDR Tracking Number
M4-12-1813

Carrier's Austin Representative
Box Number 01

MFDR Date Received
January 27, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Based on the supporting documentation attached and Creative Risk's own PLN and Peer review findings it is clear that continued denial of the disputed physical therapy claims is none other than attempt to avoid payment of necessary medical services provided to this injured worker... I respectfully request an order for Creative Risk to reimburse the services being disputed along with accrued interest."

Amount in Dispute: \$1,580.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "If a carrier has disputed the injury or extent of injury, 'the carrier will generally not be liable for the payment of benefits until there is a binding order of the Division (such as an interlocutory order) or final adjudication against the carrier."

Response Submitted by: Creative Risk Funding

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 20, 2011 through October 27, 2011	97110-GP x 4 units/per date of service	\$1,580.92	\$0.00

AMENDED FINDINGS AND DECISION

This findings and decision supersedes all previous outcomes rendered in the medical payment dispute involving the above requestor and respondent.

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.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
Explanation of benefits
 - 219 – Based on extent of injury.
 - 50 – These are non-covered services because this not deemed a medical necessity by the payer.
 - 167 – This(these) diagnosis(es) is (are) not covered
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- 216 – Based on the findings of a review organization.
- W4 – No additional reimbursement allowed after review of appeal/reconsideration.

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 28 Texas Administrative Code §124.2 of this title. The appropriate dispute process to resolve issues of compensability, extent of injury and/or liability requires the filing of a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. The division will dismiss the request until those disputes are resolved by a final decision, inclusive of all appeals.

Review of the submitted documentation finds that there are unresolved issues of compensability, extent of injury and/or liability for the same service(s) for which there is a medical fee dispute. No documentation and/or insufficient documentation was submitted to support that the issue(s) of compensability, extent of injury and/or liability were 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	March 26, 2015 Date
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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.