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 and Address
TEXAS HEALTH DBA INJURY 1 DALLAS

Respondent's Name
INDEMNITY INSURANCE COMPANY

MFDR Tracking Number
M4-12-1930-02

Carrier's Austin Representative
Box Number 15

MFDR Date Received
February 3, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The treatment that was provided is part of his compensable injury..."

Amount in Dispute: $1,629.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier submits that the services rendered were not provided as treatment for the compensable injury, and thus, reimbursement is not due from the workers' compensation carrier."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
May 19, 2011 through June 24, 2011	90806 x 3 and 90901 x 2	$1,629.21	$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 §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. This request for medical fee dispute resolution was received by the Division on February 3, 2012.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 214 – Workers Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Services denied. Please contact the SRS Claims Examiner regarding these charges
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration. The treatment billed is not authorized as it is not related to the workers compensation injury

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. The requestor seeks reimbursement for CPT Codes 90806 x 3 and 90901 x 2 rendered on May 19, 2011 through June 24, 2011. The Division notified the requestor on October 8, 2013 that the disputed services were denied due to unresolved compensability, extent of injury, liability issues. The notification letter contained information outlining the dispute path for compensability, extent of injury, liability issues. The Division finds that insufficient documentation was submitted to support that the compensability, extent of injury, liability issues were resolved prior to the submission of the Medical Fee Dispute Resolution Request.

   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. The requestor submitted insufficient documentation to support that the issue(s) of compensability, extent 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	August 10, 2018 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 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.