



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

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

KIRT W REPP  
PO BOX 9973  
THE WOODLANDS TX 77387

#### **Carrier's Austin Representative Box**

Box Number 19

#### **Respondent Name**

GREAT AMERICAN ALLIANCE INSURANCE

#### **MFDR Date Received**

APRIL 16, 2013

#### **MFDR Tracking Number**

M4-13-2057

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We are filing for MDR regarding our 4-16-2012 electrodiagnostic services for the above referenced patient. The initial claim was denied due to 'peer review'. The 'peer review' was not provided as required by current rule. We submitted a reconsideration request as per current guidelines and verified carrier receipt via fax confirmation. We received no response to the reconsideration as required by current rule. The initial claim that was denied due to rationale 'peer review' and you will find our response to that denial with detailed explanations as to why the denial is without merit as per attached 'Request for Reconsideration' dated 03-12-2013."

**Amount in Dispute:** \$3,375.00

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The Requestor's bills for these services were dispute and not being medically reasonable and necessary for the treatment of the injury of [REDACTED]. A copy of the EOB is attached. Accordingly, this is not a medical fee dispute but rather a medical necessity dispute. The proceeding should be dismissed pursuant to 28 TAC 133.307(f)(3)(B), as 'the request contains an unresolved adverse determination of medical necessity.'"

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

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 16, 2012	Professional Services	\$3,375.00	\$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. 28 Texas Administrative Code §133.100 sets out the procedures for health care under the treatment guidelines.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:  
Explanation of benefits dated August 6, 2012
  - 283 – Based on a Peer Review, payment is denied because the treatment(s)/service(s) is medical unreasonable/unnecessary.
  - W1 – Workers' Compensation jurisdictional fee schedule adjustment.
  -

### **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)(5) 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." In accordance with 28 Texas Administrative Code §133.307(f)(d)(B) 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. 28 Texas Administrative Code §137.100 Review of the submitted documentation finds that there are unresolved issues of medical necessity for the same service(s) for which there is a medical fee dispute. 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.
2. 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

\_\_\_\_\_  
Signature

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

\_\_\_\_\_  
September 30, 2015  
Date

### ***YOUR RIGHT TO REQUEST AN 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.**