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 and Address

RONALD GELZER MD
5931 DESCO DRIVE
DALLAS TX 75235

Respondent Name
EMPLOYERS PREFERRED INS CO

Carrier's Austin Representative
Box Number 04

MFDR Tracking Number
M4-14-0716-01

MFDR Date Received
October 30, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was denied as not medically necessary. The claims were resubmitted but were again denied as not medically necessary. Per TWCC Rule 133.301(a), the insurance carrier shall not retrospectively review the medical necessity of a medical bill for treatment(s) and/or service(s) for which the medical care provider has obtained preauthorization under Rule 134.600(h)."

Amount in Dispute: $930.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have received the attached MFDR and have reviewed all charges. The charges for period of 06/11/13-08/06/13 were reviewed by adjuster. Carrier will send these to Coventry to be processed for payment per state fee guidelines and ODG. The charge for 09/03/13 for total amount of $140.00 was actually already processed on 10/30/13 with check number 240299677 and paid $127.25. This check cleared on 11/19/13 by provider.

Response Submitted by: Employers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 11, 2013	99204	$260.00	$0.00
June 11, 2013 through September 3, 2013	99080-73 and 99213	$670.00	$0.00
TOTAL		$930.00	$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 October 30, 2013.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.

Issues

1. Did the insurance carrier issue payment for disputed CPT code 99080-73 rendered on June 11, 2013 and CPT codes 99213 and 99080-73 rendered on June 20, 2013 through September 3, 2013?
2. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
3. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. Communication with the requestor contact, Clara Pou on January 23, 2014 confirmed receipt of payment for disputed CPT codes 99213 and 99080-73 rendered on June 20, 2013 through September 3, 2013 and CPT code 99080-73 rendered on June 11, 2013. The requestor indicated that no payments have been received for CPT code 99204 rendered on June 11, 2013. Therefore continues to dispute CPT code 99204 rendered on June 11, 2013.
2. 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 same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of medical necessity for CPT code 99204 rendered on June 11, 2013, have been resolved prior to the filing of the request for medical fee dispute resolution.
3. The requestor has failed to support that CPT code 99204 rendered on June 11, 2013 is 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

		January 31, 2014
Signature	Medical Fee Dispute Resolution Officer	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.