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

TX HEALTH DBA INJURY 1 OF DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

Respondent Name
New Hampshire Insurance Co

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-14-0909-01

MFDR Date Received
November 19, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In summary, it is our position that Chartis Insurance has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered…"

Amount in Dispute: $1,052.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the Carrier's position that there is no money owed to the requestor, Texas Health DBA Injury 1 for the 8/27/2013 date of services for treatment. The bill has been audited two separate times, 9/17/2013 and again on 10/30/2013. The bill was denied both times because the bill lacked information as to why treatment… …was being pursued 5 years after his injury."

Response Submitted by: AIG, 4100 Alpha Road, Suite 700, Dallas, TX 75244

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 27, 2013	Professional Services	$1,052.30	$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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective and concurrent review of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information which is needed for adjudication.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

1. Did the requestor submit claim for disputed services in compliance with Division guidelines?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the disputed service as, 16 – "Claim/service lacks information which is needed for adjudication." 28 Texas Labor Code §134.600 (7) states, "all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program. Review of the submitted documentation found no evidence that the disputed service met the provisions of the Division guidelines that exempted the disputed services from pre-authorization. Therefore, the carriers' denial is supported.
2. Exemptions from prior authorization outlined in 28 Texas Labor Code §134.600 (7) not met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

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 disputed services.

Authorized Signature

		March 3, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.