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
REGENESIS BIOMEDICAL

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-14-2556-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 14, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We were paid $163.10 and when I spoke to Sherri at Texas Mutual the balance of $1636.90 was supposed to have been taken care of. I was now told to send in this dispute with respect to this balance."

Amount in Dispute: $1,636.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Because the requestor did not exhaust its remedy prior to seeking medical fee dispute resolution, DWC MDR has no jurisdiction to proceed with review."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
September 26, 2013 –October 5, 2013	E0769 and A999	$1,636.90	$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 §133.250 sets out the guidelines for reconsideration of a medical bill.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - CAC 217 – Based on payer reasonable
   - CAC 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217 – The value of this procedure is included in the value of another procedure performed on the same date.
   - 426 – Reimbursed to fair and reasonable.

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. Did the requestor submit timely reconsideration prior to requesting Medical Fee Dispute Resolution (MFDR)?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Arizona to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider did not request reconsideration from the insurance carrier prior to the Medical Fee Dispute Resolution submission. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issue(s) in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.
2. 28 Texas Labor Code §133.250(h) states in pertinent part, "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)." Review of the submitted documentation found no record of reconsideration.
3. 28 Texas Labor Code §133.307(2) states in pertinent part, "Health Care Provider or Pharmacy Processing Agent Request. The requestor shall provide the following information and records with the request for MFDR in the form and manner prescribed by the division. The provider shall file the request with the MFDR Section by any mail service or personal delivery. The request shall include... (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions)..."

   Review of the submitted documentation does not support that the Requestor utilized the reconsideration process prior to requesting MFDR therefore, the disputed services are not eligible for review.

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

Signature	Medical Fee Dispute Resolution Officer	April 16, 2015 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.