



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

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

ELITE HEALTHCARE FORT WORTH

**Respondent Name**

FREESTONE INSURANCE CO

**MFDR Tracking Number**

M4-14-2653-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

APRIL 28, 2014

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Our office does not have nay documentation on why patient shouldn't see the treating provider. All other claims have been paid in full. Sent all in for reconsideration and received denial stating same reason."

**Amount in Dispute:** \$131.39

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The treatment was not authorized...the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

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

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 5, 2013	CPT Code 99213 Office Visit	\$116.39	\$0.00
	CPT Code 99080-73 Work Status Report	\$15.00	\$0.00
TOTAL		\$131.39	\$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 §133.305 sets forth general provisions regarding dispute of medical bills.
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 §134.600 requires preauthorization for specific treatments and services.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
- Payment is denied. This treatment was not authorized.
  - Peer review done 2/13/13 by Dr. Blauzvern states no further follow ups, treatment, etc. is reasonable or medically necessary with the chiro and/or other medical provider for the right ankle injury.

**Issues**

1. Does a preauthorization issue exist?
2. Does a medical necessity issue exist?
3. Are the disputed services eligible for medical fee dispute resolution?

**Findings**

1. The respondent denied payment for the disputed services based upon “treatment was not authorized”.

The disputed office visit and work status report are not identified in 28 Texas Administrative Code §134.600(p) as a health care that requires preauthorization; therefore, the respondent’s denial for lack of preauthorization is not supported.

2. The respondent also denied payment for the disputed services based upon services were not deemed a ‘medical necessity’ by the payer.

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) that has been 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) states “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 is pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that a medical necessity issue exists, therefore, the dispute was not filed in accordance with 28 Texas Administrative Code §133.305 and §133.307.

3. 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 Division finds that the requestor has not established that 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

\_\_\_\_\_  
Date

07/25/14

### ***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.**