



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

JERALD LYNN HEAD, MD

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-14-3436-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

JULY 15, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted these bills within Timely Filing via fax to WC Carrier, Sedgwick. We have received correspondence from Sedgwick rejecting and returning the bills to us citing 'no claim on file'."

Amount in Dispute: \$1,161.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has received no report of a work-related injury from the employer or from Claimant."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include dates from August 6, 2013 to September 18, 2013, with various CPT codes and office visits, totaling \$1,161.00 in dispute and \$0.00 due.

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
3. 28 Texas Administrative Code §124.1, lists the alternative communication for reporting the injury.
4. Neither party to the dispute submitted copies of explanation of benefits for the services in dispute.

Issues

Is the requestor entitled to reimbursement?

Findings

1. The respondent states in the position summary "Carrier has received no report of a work-related injury from the employer or from Claimant."
2. 28 Texas Administrative Code §124.1(a) states "Except as provided in subsections (b) and (c) of this section, written notice of injury, as used in the Texas Workers' Compensation Act, §409.021, consists of the insurance carrier's earliest receipt of: (1) the Employer's First Report of Injury as described in §120.2 of this title (relating to Employer's First Report of Injury); (2) the notification provided by the Commission under subsection (e) of this section; or (3) if no Employer's First Report of Injury has been filed, any other communication regardless of source, which fairly informs the carrier of the name of the injured employee, the identity of the employer, the approximate date of the injury and information which asserts the injury is work related."

The requestor submitted copies of letters from Sedgwick returning the correspondence based upon "Document could not be matched to a Sedgwick claim." No documentation was submitted to support that Sedgwick has an affiliation with the respondent to support that the responsible insurance carrier ever received notice of the injury. The requestor did not submit any documentation to support that New Hampshire Insurance Co. was notified of the injury prior to medical fee dispute resolution.

3. 28 Texas Administrative Code §133.307(J) states "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)" As stated above, the requestor did not submit any documentation to support that the bills for the services in dispute were sent to New Hampshire Insurance Co.
4. 28 Texas Administrative Code §133.307(K) states "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." As stated above, the requestor did not submit any explanation of benefits or documentation requesting explanation of benefits from New Hampshire Insurance Co.
5. 28 Texas Administrative Code §133.250(i) states "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)." The requestor did not submit any documentation to support New Hampshire Insurance Co. had received the medical bills in dispute, audited them, and taken final action; therefore, the requestor has not supported that the services in dispute are eligible for medical fee dispute resolution. As a result, reimbursement is not recommended.

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

		07/29/2015
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, 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 MFDR 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.