



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

LOUIS F. PUIG, MD

Respondent Name

INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number

M4-15-2353-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

MARCH 30, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Occupational Medical Care is disputing AIG/CHARTIS's denial on the above claim. We request a resolution based on the fact that the treatment and procedures provided to the patient were indeed filed with all needed documentation and our State Billing License Number was valid as well as given."

Amount in Dispute: \$277.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that this claim was denied and has been adjudicated as non-compensable injury by the Division of Workers' Compensation."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 23, 2014	CPT Code 99203 Office Visit	\$127.51	\$0.00
	CPT Code 73610 Ankle X-Ray	\$44.14	\$0.00
	HCPCS Code L4350 Ankle Brace	\$81.25	\$0.00
	CPT Code 99080-73 Work Status Report	\$15.00	\$0.00
	HCPCS Code A9900 Miscellaneous DME Item	\$10.00	\$0.00
TOTAL		\$277.90	\$0.00

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 §133.305 sets out the procedures for resolving disputes.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - F262-The provider's State Billing License Number is Invalid or was not received pursuant to Texas Rule 133.10.

Issues

1. Has the compensability of injury issue been resolved?
2. Is the requestor entitled to reimbursement?

Findings

1. 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." The services in dispute were denied due to an unresolved compensability of injury issue. The disputed issue involved whether the injured worker sustained a compensable on the job injury on April 21, 2014. A Benefit Review Conference was held on September 10, 2014 to resolve the disputed issue. A Decision was issued on September 17, 2014 that found that the claimant did not sustain a compensable on the job injury on April 21, 2014. This decision was upheld at the Contested Case Hearing decision dated November 17, 2014. The division concludes that the compensability of the injury issue is resolved.
2. The treatments in dispute were rendered for an injury which was found not compensable according to the Benefit Review Conference and Contested Case Hearing as discussed above. The requestor rendered health care to this injured employee for the non-compensable injury; therefore, no reimbursement can be recommended for the services in dispute.

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	06/25/2015 Date
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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.