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
MARVIN E. VAN HAL, MD

Respondent Name
INDEMNITY INSURANCE CO OF NORT H AMERICA

MFDR Tracking Number
M4-15-3253-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
JUNE 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I spoke with the adjustor, Linda Reid, one time only, and she told me that the claim was denied per a peer review, and she faxed me a copy of the peer review. I spoke with the patient and she had told me that the claim had been overturned per her attorney, but I called and it had not."

Amount in Dispute: $225.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "While the Texas Workers' Compensation Act affords an injured worker medical treatment such treatment is not unlimited. It must be reasonable and necessary and related to the compensable injury. The carrier contends the Requestor's treatment for which recovery is sought was neither reasonable nor necessary nor related to the compensable injury."

Response Submitted by: The Silvera Firm

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2014	CPT Code 99214 Office Visit	$175.00	$0.00
	CPT Code 99080-73 Work Status Report	$50.00	$0.00
TOTAL		$225.00	$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 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. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 203-Peer review has determined-payment for treatment has not been recommended due to the lack of medical necessity. Peer review has provided its findings to the provider in prior documentation.
   - 216-Based on the findings of a review organization.
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - P12-Workers' compensation jurisdictional fee schedule adjustment.

Issues

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

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed services based upon reason code "203-Peer review has determined-payment for treatment has not been recommended due to the lack of medical necessity. Peer review has provided its findings to the provider in prior documentation."

   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.
2. 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 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	08/13/2015 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, 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.