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
TEXAS HEALTH DBA INJURY 1 OF DALLAS

Respondent Name
INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-15-3831-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
July 23, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The treatment that was provided is part of her compensable injury that she sustained..."

Amount in Dispute: $4,584.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the MDR request, the bill was sent for additional review. The bills are in process. Once payment has been issued, I will file an amended response."

Response Submitted by: ACE ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 22, 2014 and April 25, 2014	90837 x 2	$358.00	$0.00
March 26, 2014, April 15, 2014 and May 1, 2014 through July 25, 2014	90791, 90837 x 8, 90901 x 4 and 96151	$4,226.85	$0.00
TOTAL		$4,584.85	$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 §134.203 sets out the fee guideline for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - W-12 Charge unrelated to the compensable injury

Issues

1. Did the insurance carrier issue payment for the disputed services rendered on March 26, 2014, April 15, 2014 and May 1, 2014 through July 25, 2014?
2. Are disputed services, April 22, 2014 and April 25, 2014, eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307

Findings

1. The requestor submitted a supplemental response via e-mail stating the following "We received payment on 08/27/15 for several dates of service except for DOS 04/22/14 $290.00 & 04/25/14 $290.00." The Division finds that the requestor is no longer pursuing dispute resolution for dates of service March 26, 2014, April 15, 2014 and May 1, 2014 through July 25, 2014, however, continues to pursue dispute resolution for dates of service, April 22, 2014 and April 25, 2014. The Division will issue a decision on these two dates.
2. Review of the Explanation of Benefits (EOB's) for dates of service April 22, 2014 and April 25, 2014 were denied/reduced with reason code, "W-12 Charge unrelated to the compensable injury."

   The medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical bill review process.

   28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent-of-injury dispute for the claim.

   The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of extent-of-injury including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

   28 Texas Administrative Code §133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute. The Division finds that dates of service April 22, 2014 and April 25, 2014, were submitted prior to the resolution of the extent-of-injury issue and are therefore not eligible for review until final adjudication of the extent-of-injury issues.

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	September 3, 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.