



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

Doctors Hospital at Renaissance

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-16-1412-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

January 19, 2016

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 27 – 28, 2015	Ambulatory Surgery Center Services	\$3682.74	\$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 §122.2 sets out the procedures for reporting injuries to the Division of Workers' Compensation through the Texas Workers' Compensation System.
3. Texas Labor Code §402.00128 defines the general powers and duties of the commissioner.
4. Texas Labor Code §414.002 defines the authority of the Division of Workers' Compensation to monitor claims.

Issues

Does the Medical Fee Dispute Resolution (MFDR) office have jurisdiction to review this dispute?

Findings

Texas Labor Code §414.002(a)(1) gives the Division of Workers' Compensation the authority to monitor claims for "persons claiming benefits under this subtitle." Review of Division records and the submitted information finds that the injured employee does not have an existing claim for benefits under the Texas workers' compensation system, according to 28 Texas Administrative Code §122.2. Rather, the Division has good cause to believe that the disputed health care relates to the injured employee's claim for benefits under the Division of Longshore and Harbor Workers' Compensation.

28 Texas Administrative Code §133.307(a)(3) requires that “In resolving non-network disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the Division of Workers' Compensation (Division) is to adjudicate the payment, given the relevant statutory provisions and Division rules.” Further, 28 Texas Administrative Code §133.307(f)(3) states, in relevant part, “The division may dismiss a request for MFDR if: (D) the division determines that good cause exists to dismiss the request.” The division finds that MFDR does not have jurisdiction to review this dispute.

DECISION

Based upon the documentation submitted by the parties, the Division has determined that this dispute is not eligible for resolution pursuant to 28 Texas Administrative Code §133.307.

Authorized Signature

	Laurie Garnes	February 18, 2016
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, 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).