TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Houston Medical Group

MFDR Tracking Number
M4-17-0167-01

MFDR Date Received
September 21, 2016

Respondent Name
Federal Insurance Co

Carrier's Austin Representative
Box Number 17

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have done all the above to make sure that what we did was the correct outcome. "

Amount in Dispute: $3,000.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel maintains the requestor, Houston Medical Group is not entitled to reimbursement for date of service 12/16/15 based on extent of injury."

Response Submitted by:

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
July 31 – 2015 through December 16, 2015	Physical medicine	$6,815.79	$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 §133.305 sets out the procedure for dispute resolution.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 219 – Based on Extent of Injury

Issues

1. Have the relevant compensability issues 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, in part, due to unresolved extent of injury issues. The issues raised and relevant to the services in this medical fee dispute involved whether the compensable injury extended to left knee medial meniscal tear. A contested case hearing decision issued on September 15, 2016. It its decision, the division concluded that compensable injury of October 18, 2014 **did not include** left knee medical meniscal tear. The division finds that the relevant issues were resolved.

2. Review of the submitted medical records found the diagnosis of 8360; "Tear of medical cartilage or meniscus of knee." The division concludes that the services in dispute were rendered by the requestor to treat an injury found to be non-compensable according to the Contested Case Hearing decision discussed above. For that reason, no reimbursement can be 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

		April 5, 2019
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).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.