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
APRIA HEALTHCARE INC

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-19-3889-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 22, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: $186.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Until the issue of compensability has been finally adjudicated no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2019	E1390	$186.78	$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. Neither the requestor nor the respondent submitted EOBs for consideration in this dispute.

Issues

1. Did the requestor meet the requirements of 28 Texas Administrative Code §133.307?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement DME code E1390, rendered on January 9, 2019. Review of the submitted documentation finds the following:

   28 Texas Administrative Code §133.307(c)(2)(J), requires that the request shall include "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions)." Review of the submitted documentation finds that the requestor has not provided a copy of the medical bill(s) as originally submitted to the carrier and/or as submitted for reconsideration. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(J).

   28 Texas Administrative Code §133.307(c)(2)(K), requires that the request shall include "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." Review of the submitted documentation finds that the request does not include copies of any EOBs for the disputed services. Nor has the requestor provided evidence of carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(K).

   28 Texas Administrative Code §133.307(c)(2)(M), requires that the request shall include "a copy of all applicable medical records related to the dates of service in dispute." Review of the submitted documentation finds that the requestor has not provided copies of all medical records specific to the dates of service in dispute. Although the requestor submitted a copy of a preauthorization approval it was dated August 13, 2012, the requestor does not indicate how this document relates to the disputed service. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(M).

   28 Texas Administrative Code §133.307(c)(2)(N)(i), requires that the request shall include a position statement including "the requestor's reasoning for why the disputed fees should be paid or refunded." Review of the submitted documentation finds that the requestor has not provided reason for why the disputed fees should be paid. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N)(i).

   28 Texas Administrative Code §133.307(c)(2)(N)(ii), requires that the request shall include a position statement including "how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues." Review of the submitted documentation finds that the requestor has not discussed how the Labor Code, Division rules and fee guidelines impact the disputed fee issues. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N)(ii).

   28 Texas Administrative Code §133.307(c)(2)(N)(iii), requires that the request shall include a position statement of the disputed issues including "how the submitted documentation supports the requestor's position for each disputed fee issue." Review of the submitted documentation finds that the requestor has not discussed how the documentation supports their position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(N)(iii). The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated

2. The Division finds that the requestor submitted insufficient documentation for consideration in this dispute. As a result, $0.00 is recommended for the services rendered on January 9, 2019.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position 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 services in dispute.

Authorized Signature

		August 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, 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.