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
NORTH TEXAS PAIN RECOVERY CENTER

MFDR Tracking Number
M4-20-0048-01

MFDR Date Received
September 9, 2019

Respondent Name
LIBERTY INSURANCE CORP.

Carrier's Austin Representative
Box Number 01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A BRC on network notice was held on May 9, 2019 at which time carrier's attorney Jane Lipscomb Stone of Stone, Laughlin,& Swanson agreed that the claimant was not properly notified of network requirements. Pursuant to that agreement and Texas Insurance Code 1305.005 the carrier is liable under Title 5 Labor Code... Additionally the carrier paid bills which were denied as 'out of network' but reserved payment of the enclosed bills due to the ongoing EOI and Relatedness issues which were subsequently decided at CCH... The ALJ has found that... disability extended from the January 22, 2019 until March 17, 2019. The ALJ further states that the treatment by North Texas Pain Recovery Center is related to the compensable injury. EOB's were not available at the time of this request and attempts to contact Liberty Mutual were Met with unreturned messages and hold times over [sic] an hour at the toll-free number provided on existing EOB's."

Amount in Dispute: $26,600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In accordance with Chapter 28 TAC §10.121, an investigation has been completed on your issue. The bills have been reviewed and denial stand per PLN 11 filed: '... All other injuries, conditions, diagnoses, and/or symptoms related to the injured body part or any other part of the claimant's body are denied as not resulting from the compensable injury or accident. Copy of PLN is submitted for your review. If you are dissatisfied with this resolution, you may file a complaint with the Texas Department of Insurance (TDO)..."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount in Dispute	Amount Due
January 22, 2019 through February 22, 2019	97799-CP-CA	$26,600.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code(TLC) §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.600 sets out the guidelines for preauthorization, concurrent review, and voluntary certification of healthcare.
3. 28 TAC §134.203 sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
4. Neither party submitted copies of EOBs with the request for Medical Fee Dispute Resolution.

Issues

1. Did the requestor submit documentation in accordance with 28 TAC §133.307?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for a chronic pain management program rendered on January 22, 2019 through February 22, 2019.

   28 TAC §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 . . . 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 insurance carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of 28 TAC §133.307(c)(2)(K).

   28 TAC §133.307(c)(2)(M), requires that the request shall include "a copy of all applicable medical records specific 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. The Division concludes that the requestor has not met the requirements of 28 TAC §133.307(c)(2)(E).

   28 TAC §133.307(c)(2)(Q), requires that the request shall include 'any other documentation that the requestor deems applicable to the medical fee dispute."

   The requestor refers to a BRC agreement to support that the insurance carrier did not provide the injured employee with proper notice of network status, therefore, waiving the right to process the claim within the network. However, the requestor did not provide a copy of the referenced BRC agreement with the DWC60 request for consideration in this dispute.
2. Review of the submitted documentation finds that the requestor submitted insufficient documentation to support the filing of the DWC060 request. As a result, the dispute is ineligible for MFDR review.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that the dispute is eligible for review. 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 TLC §413.031, the DWC has determined that the requestor is not entitled to reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 18, 2019 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 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 TAC §141.1(d).

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