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
MEDICAL CENTER OF SOUTHEAST TEXAS

Respondent Name
LIBERTY INSURANCE CORP.

MFDR Tracking Number
M4-20-0082-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
September 12, 2019

Response Submitted By
Liberty Mutual

REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement for consideration in this review.

RESPONDENT'S POSITION SUMMARY

"The bill for 6/3/2019 was submitted without a request for reconsideration being previously submitted. Division rules require that the bill must be the submitted for reconsideration prior to DWC060 being filed."

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
June 3, 2019	Outpatient Hospital Diagnostic Services	$29.48	$0.00

AUTHORITY

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

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 243 – THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED.
   - 97 – [No description of this code was found with the submitted materials.]

Issues

Is the request eligible for medical fee dispute resolution (MFDR)?

Findings

The respondent asserts, "The bill for 6/3/2019 was submitted without a request for reconsideration being previously submitted. Division rules require that the bill must be the submitted for reconsideration prior to DWC060 being filed."

DWC Rule 28 Texas Administrative Code §133.250(i) provides that:

> If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills).

The health care provider presented no information to show they requested reconsideration from the insurance carrier before requesting MFDR.

Rule 28 TAC §133.307(c)(2) further requires the provider, when requesting MFDR, to include the following information and documents with their request:

(A) the name, address, and contact information of the requestor;
(B) the name of the injured employee;
(C) the date of the injury;
(D) the date(s) of the service(s) in dispute;
(E) the place of service;
(F) the treatment or service code(s) in dispute;
(G) the amount billed by the health care provider for the treatment(s) or service(s) in dispute;
(H) the amount paid by the workers' compensation insurance carrier for the treatment(s) or service(s) in dispute;
(I) the disputed amount for each treatment or service in dispute;
(J) 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);
(K) 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;
(L) when applicable, a copy of the final decision regarding compensability, extent of injury, liability and/or medical necessity for the health care related to the dispute;
(M) a copy of all applicable medical records related to the dates of service in dispute;
(N) a position statement of the disputed issue(s) that shall include:
    (i) the requestor's reasoning for why the disputed fees should be paid or refunded,
    (ii) how the Labor Code and division rules, including fee guidelines, impact the disputed fee issues, and
    (iii) how the submitted documentation supports the requestor's position for each disputed fee issue;
(O) documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable;
(P) if the requestor is a pharmacy processing agent, a signed and dated copy of an agreement between the processing agent and the pharmacy clearly demonstrating the dates of service covered by the contract and a clear assignment of the pharmacy's right to participate in the MFDR process. The pharmacy processing agent may redact any proprietary information contained within the agreement; and
(Q) any other documentation that the requestor deems applicable to the medical fee dispute.

Providers may find the most current versions of workers' compensation rules either directly from the DWC website at: https://www.tdi.texas.gov/wc/rules/index.html

Or from the Texas Secretary of State's website: https://texreg.sos.state.tx.us/public/tacctx$.startup

Review of the submitted materials finds the requestor failed to supply a copy of any explanation of benefits showing the carrier's response to the request for reconsideration—as required by Rule 28 TAC §133.307(c)(2)(K)—or in the absence of a carrier response, convincing evidence of insurance carrier receipt of the request for an EOB.

Additionally, the requestor failed to include a position statement—as required by Rule 28 TAC §133.307(c)(2)(N)—which should contain the reasoning why the disputed fees should be paid, how the Labor Code or DWC rules apply to the circumstances, and an explanation of how the submitted documents support the requestor's position.

While we at MFDR do our best to decide the issues based on all the information available at the time of review, we urge requestors to supply the above listed information, or anything else the requestor feels might be persuasive, so that we may conduct a thorough review.

In this case, the submitted information did not support that the health care provider gave the insurance carrier an opportunity to reconsider their original payment determination. Because the provider did not meet the requirements of Rule 28 TAC §133.250, this request for MFDR is not eligible for review.

Conclusion

In resolving 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 is to adjudicate the payment, given the relevant statutory provisions and division rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

Because the provider did not request reconsideration from the insurance carrier, this dispute is not eligible for review. As a result, the amount ordered is $0.00.

ORDER

In accordance with Texas Labor Code §413.031, based on the information submitted for review, DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	October 11, 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 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

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