TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
TRENTON DAVID WEEKS DC

Respondent Name
TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number
M4-22-0569-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
November 18, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 29, 2020	99456-NM	$350.00	$0.00
	Total	$350.00	$0.00

Requestor's Position

"I performed this examination at the request of the injured employee and the treating doctor... This report and bill was performed according to TDWC rules and should be paid in full."

Amount in Dispute: $350.00

Respondent's Position

"The Provider contends they are entitled to reimbursement as the Treating Doctor requested the evaluation and the Provider is certified to perform it. As documented on the Explanation of Benefits, the Carrier disputed reimbursement on the basis that the Carrier had disputed the compensability of the injury. The Carrier disputed compensability by filing a PLN-11 on 01-31-2020. A Contested Case Hearing was held on 05-26-2021, and the Administrative Law Judge determined that the claim was not compensable. The Appeals Panel upheld the Decision. Therefore, as the injury is not compensable, the Carrier has no liability for any benefits. Consequently, the Provider is not entitled to reimbursement. The Division should hold the Provider is not entitled to reimbursement, or in the alternative, this dispute should be dismissed under Rule 133.307(f)(3)(D)."

Response Submitted by: Travelers

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §133.305 sets out the procedures for dispute resolution.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 131 – Claim specific negotiated discount
- 96 – Non-covered charge(s)
- W3 – No additional reimbursement allowed after review of appeal/reconsideration/request for second review
- 197 – Recommended allowance based on negotiated discount/rate
- 5677 – The procedure/service is not reimbursable because the workers compensation claim has been denied based on compensability, disability, or a combination of reasons.

Issues

1. Have the relevant compensability issues been resolved?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for a treating doctor ordered examination, CPT Code 99456-NM rendered on December 29, 2020. The insurance carrier denied reimbursement of the disputed service with denial reasons 96, and 5677 (description provided above.)

   28 TAC §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 TAC §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 service in dispute was due to compensability. The insurance carrier states in relevant part, "...the Administrative Law Judge determined that the claim was not compensable." The issues raised and relevant to the service in this medical fee dispute involved whether the injured employee sustained a compensable injury. A contested case hearing (CCH) was held, and a

decision was issued on May 26, 2021. The division concluded the following "Claimant did not sustain a compensable injury on [date of injury]… Insurance Carrier is not liable for benefits, and it is so ordered."

The requestor's service in dispute was provided for the date of injury indicated in the CCH. The division finds that the relevant issue was resolved on June 3, 2021 and found that the injured employee did not sustain a compensable injury on [date of injury].

2. Review of the submitted documentation indicates that the requestor treated the injured employee for a date of injury that was found to be non-compensable according to the CCH decision issued on June 3, 2021. For that reason, no reimbursement can be recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

The DWC finds that the requester has not established that reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to reimbursement for the services in dispute.

Authorized Signature

		December 8, 2021
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.