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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
METHODIST MEDICAL CENTER

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-98-2816-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
JULY 16, 1997

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: No position statement found and/or provided

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No position statement found and/or provided

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount Due
September 20, 1996 through September 26, 1996	Inpatient Hospital Services	$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. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the general procedures for medical dispute resolution.
2. Former 28 Texas Administrative Code §102.5, adopted to be effective July 29, 1991, 16 *Texas Register* 3939; amended to be effective March 15, 1995, 20 Texas Register 1418, sets out the guidelines for written communications from the Division, formerly the Commission.
3. The former agency's *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.400, 17 *Texas Register* 4949, was declared invalid in the case of the *Texas Hospital Association v. Texas Workers' Compensation Commission, 911 South Western Report Second 884* (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the dispute services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the provider Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission, 125 South Western Reporter Third 96* (Texas Appeals – Austin, 2003, petition for review denied).
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.

Findings

Records indicate that Medical Fee Dispute Resolution (formerly Medical Review) docketed a request for dispute resolution from healthcare provider Methodist Medical Center on October 1, 1997. On April 9, 2014 the parties to the dispute were notified that the Division was unable to locate documentation originally submitted associated with dispute M4-98-2816-01. This notice was made by letter which was sent to:

(1) The requestor via regular mail to the address provided on the original DWC-060 form
(2) The respondent via its Austin representative box

The letter to the parties included a request for the following documents:

(1) The original request for dispute resolution
(2) Additional information originally and timely submitted to the Division
(3) Copies of correspondence
(4) Any additional information that the parties would like to provide

To date the Division has no record of receiving any documentation from the requestor, respondent, nor from any representatives of the respondent or requestor.

Former 28 Texas Administrative Code §133.305, effective June 3, 1991, states, in pertinent part, "(k) The division of medical review shall proceed with the review of the medical dispute after all required and requested information has been received." No documentation was provided by the requestor upon the division's (formerly Medical Review); consequently, the division finds that the requestor has failed to support its request for additional reimbursement.

Conclusion

The Division concludes the requestor has not supported its request for reimbursement. 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

Signature	Medical Fee Dispute Resolution Officer	October 23, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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