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
PREBYTERIAN HOSPITAL PLANO

Respondent Name
STATE FARM GENERAL INSURANCE COMPANY

MFDR Tracking Number
M4-98-9153

Carrier's Austin Representative
Box Number 01

MFDR Date Received
July 14, 1997

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 10 to July 15, 1996	Inpatient Hospital Services	$17,127.75	$0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §141.1 sets out the procedures for requesting a benefit review conference.
3. Texas Labor Code Chapter 410 Subchapter B. sets out procedures regarding benefit review conferences.
4. The requestor did not submit copies of explanations of benefits regarding the insurance carrier's payment determinations for the disputed services.

Issues

1. Did the requestor provide copies of all written communications and memoranda relating to the dispute?
2. Are there unresolved issues of compensability, extent of injury, or liability regarding the services in dispute?
3. Can the Division adjudicate the medical fee issues in this dispute?

Findings

1. The requestor has not submitted the request in the form and manner required by Division rule. 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "copies of all written communications and memoranda relating to the dispute." Review of the documentation submitted by the requestor finds that the request does not include copies of any explanations of benefits regarding the insurance carrier's payment or denial of the disputed services. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).
2. The respondent's position statement asserts, "their dispute is with another carrier and for a different Workers' Compensation claim and injury from the one we were responsible for providing benefits. . . . In

conclusion, it is the respondent's position that this filing for a Medical Dispute Resolution against State Farm is not in order since we are not responsible for the 1995 injury for which this dispute was filed."

Review of the submitted documentation finds that there are unresolved issues of compensability, extent of injury, or liability for the same service(s) for which there is a medical fee dispute. No documentation was presented to support that the issue(s) of compensability, extent or liability have been resolved.

The appropriate dispute process for unresolved issues of compensability, extent of injury, or liability regarding disputed services requires the health care provider to submit a request for a benefit review conference pursuant to 28 Texas Administrative Code §141.1. All outstanding issues regarding compensability, extent of injury, or liability for the disputed services must be resolved before requesting medical fee dispute resolution.

3. The requestor has failed to support that the outstanding issues regarding compensability, extent of injury or liability for the disputed services have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 before submitting a request for medical fee dispute resolution regarding the same services. Consequently, the Division cannot review the medical fee issues in dispute.

Conclusion

For the reasons stated above, the Medical Fee Dispute Resolution section cannot review the disputed services. As a result, no additional payment can be ordered. The merits of the medical fee issues have not been addressed.

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 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	September 30, 2015
Signature	Medical Fee Dispute Resolution Officer	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 MFDR 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 this *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.