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
COMBINED CHIROPRACTIC SERVICES & REHAB

Respondent Name
UTICA MUTUAL INSURANCE CO

MFDR Tracking Number
M4-12-0614

Carrier's Austin Representative
Box Number 01

MFDR Date Received
October 24, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medical necessity was established by his treating doctor Douglas Burke. The service performed was an office visit for established patient, which met the following criteria... The criteria were met according to the OGD guidelines and the definition of the office visit for an established patient and there are no grounds for the denial."

Amount in Dispute: $190.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not include a position summary with the DWC060 response.

Response Submitted by: Utica National

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
April 6, 2011 and May 4, 2011	99213 x 2	$190.00	$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 out the general Medical Dispute Resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.

Issues

1. What are the denial reason(s) raised by the insurance carrier during the bill review process?
2. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of medical necessity?
3. Are the disputed services eligible for review by Medical Fee Dispute Resolution?
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 216 – Based on the findings of a review organization
   - 244 – Unnecessary medical
   - 50 – These are non-covered services because this is not deemed a medical necessity by the payer.

Findings

1. The medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of medical necessity for the same service(s) for which there is a medical fee dispute. Review of the EOBs presented by the both the requestor and respondent indicate denial reason codes "216 – Based on the findings of a review organization, 244 – Unnecessary medical, 50 – These are non-covered services because this is not deemed a medical necessity by the payer."
2. Review of the submitted documentation finds that the medical fee dispute referenced above contains information/documentation that indicates that there are **unresolved** issues of medical necessity for the same service(s) for which there is a medical fee dispute.
3. The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives.***

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…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 medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

   The division finds that due to the unresolved medical necessity issues, the medical fee dispute request is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This dismissal is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. The Division finds that this dispute is not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307.

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

		May 6, 2016
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.