



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

COMBINED CHIROPRACTIC SERVICES & REHABILITATION

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-12-0691

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 2, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...DD doctor...agrees that the patient is not at MMI and he is in her favor that the patient has sustained a work injury and the [sic] it is compensable and the DD also states that the patient is a candidate for surgery and the adjuster has not made payments for this [sic] dates of service for the patient in question."

Amount in Dispute: \$795.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on November 4, 2011. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
July 1, 2010 through November 15, 2010	99204 and 99213 x 6	\$795.00	\$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

- 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 218 – Based on entitlement to benefits
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307?
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. The medical fee dispute referenced above contains information/documentation that indicates there are **unresolved** issues of compensability, extent-of-injury and/or liability (CEL) 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 code “218 – Based on entitlement to benefits.”

28 Texas Administrative Code §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 Texas Administrative Code §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.”

28 Texas Administrative Code §133.307(e)(3)(H), requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to 28 Texas Administrative Code §124.2 of this title. The appropriate dispute process to resolve issues of compensability, extent of injury and/or liability requires the filing of a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. The division will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals.

Review of the submitted documentation finds that there are unresolved issues of compensability, extent of injury and/or liability for the same service(s) for which there is a medical fee dispute. The requestor submitted insufficient documentation to support that the issue(s) of compensability, extent of injury and/or liability were resolved prior to the filing of the request for medical fee dispute resolution.

2. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent’s denial of payment reasons concerning liability for the injured employee’s workers’ compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

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 services in dispute.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

May 6, 2016
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.