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
ACADIAN AMBULANCE

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

MFDR Tracking Number
M4-12-3496-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 1, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please reprocess this date of service for payment."

Amount in Dispute: $1,334.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual's Benefit Administrator denied compensability of the entire claim on 8/29/11. A Decision & Order was issued on 4/18/12 finding that the claimant did not sustain a compensable injury and the carrier is not liable for payment of benefits. The Appeals Panel affirmed the Decision & Order on 7/13/12. Thus, no payment is due the requesting party in this dispute."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
August 30, 2011	Ambulance Charges	$1,334.42	$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. 28 Texas Administrative Code §133.305, sets out the procedures for resolving medical fee disputes.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC 218 – Based on entitlement to benefits.
   - 245 – The carrier is disputing the liability of the claim or compensation of the injury. Final adjudication has not taken place.
   - CAC 18 –Duplicate claim/service.
   - CAC 29 – The time limit for filing has expired.
   - 224 – Duplicate charge.
   - 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 9/1/05.
   - CAC 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891 – No additional payment after reconsideration.

Issues

1. Has the liability issue been resolved?
2. Is the requestor entitled to reimbursement?

Findings

1. 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."

   The services in dispute were denied, in part, due to an unresolved compensability issue. The disputed issue involved whether the injury was accepted by the division as a compensable injury. A CCH decision was not in favor of the claimant. An appeal was issued of the CCH and the Appeal's Panel Decision affirmed the Decision & Order on July 13, 2012. As a result, the division concludes that the compensability issue is resolved.

2. The division records indicate that the compensability was not accepted. The requestor rendered health care to this injured employee for a non-compensable injury; therefore, no reimbursement can be recommended for the services in dispute.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. 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	April 16, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all 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*** along with any other required information specified in 28 Texas Administrative Code §141.1(d).

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