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 and Address

TX HEALTH DBA INJURY 1 OF DALLAS
9330 LBJ FREEWAY SUITE 1000
DALLAS TX 75243

Respondent Name
American Zurich Insurance Co

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-13-2661-01

MFDR Date Received
June 17, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In summary, it is our position that Zurich has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered…"

Amount in Dispute: $1,148.15

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There is an inconsistency between the DWC-60 Table of Disputed Services and the billing documents. The Table of Disputed Services listed the CPT Code as 90801. The submitted bills list CPT Codes 90791 and 90889. The request for review is not properly completed and should be dismissed pursuant to 28 TAC 134.307(f)(3)(D) as the Requestor has failed to comply with the requirements of the rule."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 14, 2013	Professional Services	$1,148.15	$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 §133.307 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:
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - W1 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT

Issues

1. Did the requestor submit the request for medical fee dispute resolution in compliance with Division guidelines?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(2)(F) states, "the treatment or service code(s) in dispute". Review of the submitted documentation finds;
    a. Medical bill contains codes 90791 and 90889
    b. The explanation of benefits included with the documentation is for codes 90791 and 90889.

   Review of the documentation finds the request and documentation do not match. The Division guidelines have not been met.
2. No additional can be recommended based on the submitted request and documentation.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional 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

		March 3, 2014
Signature	Medical Fee Dispute Resolution Officer	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 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 §141.1(d).

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