



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Comprehensive Hearing Center of Texas

**Respondent Name**

Starr Specialty Insurance Co

**MFDR Tracking Number**

M4-24-0900-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

December 20, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 15, 2023	V5261	\$7,000.00	\$0.00
August 15, 2023	V5268	\$2,000.00	\$0.00
August 15, 2023	V5267	\$350.00	\$0.00
August 15, 2023	V5267	\$450.00	\$0.00
August 15, 2023	V5267	\$499.00	\$0.00
August 15, 2023	V5268	\$350.00	\$0.00
August 15, 2023	V5270	\$450.00	\$0.00
August 15, 2023	V5264	\$300.00	\$0.00
August 15, 2023	V5160	\$300.00	\$0.00
<b>Total</b>		<b>\$11,699.00</b>	<b>\$0.00</b>

### Requestor's Position

"This claim was incorrectly denied as 'NOT A 'MEDICAL NECESSITY' BY THE PAYER.' If you look at the attached Certification you will see that this claim was 'Medically Certified.' If the claim was reviewed properly this injured worker would already have his hearing aids. This injured worker has been waiting since August..."

**Amount in Dispute:** \$11,699.00

## Respondent's Position

The Austin carrier representative for Starr Specialty Insurance Co is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on January 3, 2024. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

## Findings and Decision

### Authority

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

### Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §133.10](#) sets out required billing formats.
3. [Texas Labor Code §413.011](#) sets forth provisions regarding reimbursement policies and guidelines.

### Denial Reasons

- 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
- N661 – Documentation does not support that the services rendered were medically necessary.
- PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not 'reasonable or necessary'. The amount adjusted is generally not the patient's responsibility, unless the workers' compensation state law allows the patient to be billed.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005– No additional reimbursement allowed after review of appeal/reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – Bill is reconsideration or appeal.

Issues

1. Did the requestor submit the bill per DWC guidelines?

Findings

1. The requestor seeks reimbursement for services billed for dates of service August 15, 2023. The requestor states in their position statement, "...If the claim was reviewed properly this injured worker would already have his hearing aids. This injured worker has been waiting since August. This claim needs to be paid... ..so we can fit the patient and issue his hearing aids and accessories without further delay."

DWC Rule 28 TAC §133.10 (f)(1)(O) requires date or dates of service is required. The date of service is defined as the date the patient received the service or item. As the requestor indicates the injured worker HAS NOT received the services on the submitted medical bill, the date of service is invalid. No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

**Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 additional reimbursement for the disputed services.

**Authorized Signature**

		July 10, 2024
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).