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
Allied Medical Centers

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-11-0104-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 3, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has sent two status requests and a request for reconsideration, all of which have not been replied to. Therefore does not give us an avenue to properly seek reimbursement for services we provided. This is also in violation of Rule 133.240."

Amount in Dispute: $221.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received September 13, 2010 however, no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 16, 2009	99214, 99080, 99455	$221.00	$15.00

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. 28 Texas Administrative Code §133.200 sets out procedures for insurance carriers upon receipt of medical bills.
3. 28 Texas Administrative Code §129.5 sets out the guidelines for reimbursement of work status reports.
4. 28 Texas Administrative Code §134.202 applies to professional medical services provided in the Texas Workers' Compensation system.
5. No explanation of benefits was submitted by either party.

Issues

1. Did the respondent adjudicate and/or respond to requestor as required by the Division?
2. Did the requestor submit a medical bill that complied with Division Rules and Guidelines?
3. Is the requestor entitled to reimbursement?

Findings

1. 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 September 13, 2010. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 Texas Register 3954, "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." Accordingly, this decision is based on the available information.
2. Per 28 Texas Administrative Code §133.240(a) states in pertinent part, "An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation." No documentation was submitted by respondent to support that final action was taken on the services in dispute within Division requirements. The services in dispute will be reviewed per applicable rules and fee guidelines.
3. Review of the submitted medical claim finds the following;
    - Per 28 Texas Administrative Code §134.202 (6) states in pertinent part, "Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: (C) The following applies for billing and reimbursement of an MMI evaluation. (i) An examining doctor who is the treating doctor shall bill using the "Work related or medical disability examination by the treating physician..." CPT code with the appropriate modifier. (I) Reimbursement shall be the applicable established patient office visit level associated with the examination. (II) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit."
    - The medical bill was submitted with CPT code 99214 however, no "V" modifier was included with the claim. The provisions of Rule 134.202 were not met in regards to this code. No separate payment can be recommended.
    - Per 28 Texas Administrative Code §129.5(i) "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section;" Review of the submitted medical claim finds the requestor submitted code 99080 with 73 modifier. Requirements of Rule 129.5 are met, additional reimbursement in the amount of $15.00 can be recommended.
    - Per 28 Texas Administrative Code §134.202 (6)(F) states in pertinent part, "The treating doctor is required to review the certification of MMI and assignment of IR performed by another doctor, as stated in the Act and commission Rules, Chapter 130 relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by A Doctor Other Than The Treating Doctor. The treating doctor shall bill using the "Work related or medical disability examination by the treating physician..." CPT code with modifier "VR" to indicate a review of the report only, and shall be reimbursed $50.00." Review of the medical bill finds that code 99455 was billed with modifier "VR". However, the submitted documentation does not support that the treating doctor reviewed the report of another physician. No separate reimbursement can be recommended.
4. The total allowed charges is $15.00. The carrier made no previous payments. The Division finds the balance of $15.00 is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $15.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $15.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		November 17, 2014
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 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.