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
KEITH A CROW, MD

Respondent Name
EAST TX EDUCATIONAL INS ASSN

MFDR Tracking Number
M4-14-3054-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
JUNE 9, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are attaching the patient's demographics that show Dr. Ellen Linn M.D. is the referring provider."

Amount in Dispute: $99.11

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Treating Physician for this Workers Compensation claim is Richard Neel M.D. The physician ordering the services in question (Ellen Lin M.D), is the claimant's PCP and not the approved Workers Compensation physician on this claim. Therefore, any services ordered by her or rendered by another provider via her orders, would not be eligible for benefits."

Response Submitted by: Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 26, 2013	CPT Code 72114 Lumbar Spine X-ray	$99.11	$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. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §180.22, effective January 9, 2011 requires the treating doctor to recommend and coordinate all of the claimant's health care except in emergency.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 171, 185-The rendering provider is not eligible to perform the service billed.
   - 350-Bill has been identified as a request for reconsideration or appeal.

- W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
- Our records indicate the referring provider, Ellen Lin, is not an approved treating or referral physician. Denial is maintained.

Issues

Were the disputed services rendered in accordance with 28 Texas Administrative Code §180.22(c)(1)? Is the requestor entitled to additional reimbursement?

Findings

According to the submitted explanation of benefits, the respondent denied reimbursement for the lumbar x-rays based upon "Our records indicate the referring provider, Ellen Lin, is not an approved treating or referral physician. Denial is maintained."

The respondent states "The Treating Physician for this Workers Compensation claim is Richard Neel M.D. The physician ordering the services in question (Ellen Lin M.D), is the claimant's PCP and not the approved Workers Compensation physician on this claim."

28 Texas Administrative Code §180.22(c)(1) states "The treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury. The treating doctor shall: (1) except in the case of an emergency, approve or recommend all health care reasonably required that is to be rendered to the injured employee including, but not limited to, treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers, as defined in this section."

The requestor did not submit documentation to support that the treating doctor approved or recommended the disputed lumbar x-rays. In addition, the submitted documentation does not support that the disputed service was rendered in the case of an emergency to meet exception in 28 Texas Administrative Code §180.22(c)(1). As a result, reimbursement is not recommended.

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	01/09/2015 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 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.