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
James Bales, MD

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-15-0229-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 16, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was denied in error. This was for a Division ordered Designated Doctor Exam. We billed a total of $500.00 for this claim but were paid 0. The explanation given on the EOB justifying the denial states: Billing error. Attached is corrected 1500. The reduction of parts of this claim of is in violation of the rules of the Texas Department Insurance Division of Workers' Compensation as this service was ordered on the DWC-32."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: 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 24, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. 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." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 2, 2014	Designated Doctor Examination to Determine Extent of Injury	$500.00	$500.00

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 §134.204 sets out the billing procedures and fee schedule for Designated Doctor Examinations.

3. 28 Texas Administrative Code §133.3 provides guidance regarding the communication requirements between providers and carriers for billing.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

Issues

1. Were the services in question billed correctly according to 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (i)(1), "Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: (C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, **with the use of the additional modifier 'W6;'**" [emphasis added].

   28 Texas Administrative Code §134.204 (k) states, "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination**, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE."** In either instance of whether MMI/IR is performed or not, **the reimbursement shall be $500** in accordance with subsection (i) of this section and shall include Division-required reports" [emphasis added].

   Review of the submitted documentation finds that the requestor performed a Division-ordered Designated Doctor's Examination to determine extent of the compensable injury. The submitted CMS-1500 indicates that the requestor billed for this examination using CPT 99456 with modifiers W6 and RE.

   28 Texas Administrative Code §133.3 (a) states, "Any communication between the health care provider and insurance carrier related to medical bill processing **shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill**. Generic statements that simply state a conclusion such as "insurance carrier improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section" [emphasis added]. Therefore, the Division finds that the services in question were billed correctly according to 28 Texas Administrative Code §134.204.
2. The insurance carrier denied payment stating, "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication." This denial was not supported by the submitted documentation, therefore, the requestor is entitled to reimbursement of $500.00 per 28 Texas Administrative Code §134.204 (k).

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 $500.00.

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 $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	January 6, 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.