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
Michele D. Reynolds, MD

Respondent Name
Fedex Freight, Inc.

MFDR Tracking Number
M4-15-0347-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 22, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "**NON PAYMENT FOLLOWING CARRIER'S RECEIPT OF INITIAL SUBMISSION**

We are re-submitting the attached claim to you in accordance and compliance with TDI-DWC Rule 133.250 and respectfully request you respond to our office within **30 days** of receipt of this documentation per Rule 133.250 (g)…

We have attached a copy of the original claim/bill and documentation as originally submitted…"

Amount in Dispute: $1565.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. The bill submission was not timely."

Response Submitted by: Flahive, Ogden & Latson, Post Office Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 8, 2013	Designated Doctor Examination	$1565.00	$1550.00

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 §133.20 (b) provides the filing deadline for medical billing.
3. Texas Labor Code §408.0272 provides exceptions to the filing deadline for medical billing.
4. 28 Texas Administrative Code §133.210 (e) defines simultaneous possession of information among entities.
5. 28 Texas Administrative Code §134.204 sets out the procedures for billing and reimbursing Designated Doctor Examinations.

6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 937 – Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.

Issues

1. Did the requestor submit billing for the disputed services within a timely manner as defined by 28 Texas Administrative Code §133.20 (b)?
2. Is the requestor entitled to reimbursement?

Findings

1. The TPA for this claim, Sedgwick Claims Management Services, denied the requested services stating, "Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service." Per 28 Texas Administrative Code §133.20 (b), "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided."

   A review of the submitted documentation finds that the requestor submitted the initial bill with documentation for date of service 10/8/13 on 10/29/13 in an e-mail to ELIZABETH.HERNANDEZ@SEDGWICKCMS.COM. 28 Texas Administrative Code §133.210 (e) states, "It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other." Therefore, the documentation supports that the requestor submitted a bill to the insurance carrier in a timely manner as defined by 28 Texas Administrative Code §133.20 (b).
2. Review of the submitted documentation finds that the requestor performed ordered examinations for maximum medical improvement, impairment ratings of upper extremity and lower extremity, extent of injury, and return to work and billed according to 28 Texas Administrative Code §134.204. Billed CPT Code 99456 with modifier W5 at the rate of $15.00 is not found in 28 Texas Administrative Code §134.204, so is not payable. Therefore, the requestor is entitled to reimbursement of $1550.00 as set out in the fee schedule of the same rule. See the table below for detailed information.

Services Performed	Allowable Amount	Applicable Rule
Maximum Medical Improvement	$350.00	§134.204 (j)(3)(C)
Impairment Rating (ROM UE)	$300.00	§134.204 (j)(4)(C)(ii)(II)(-a-)
Impairment Rating (ROM LE)	$150.00	§134.204 (j)(4)(C)(ii)(II)(-b-)
Extent of Injury	$500.00	§134.204 (k)&(i)(2)(A)
Return to Work	$250.00	§134.204 (k)&(i)(2)(B)
Total	$1,550.00	

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 $1550.00.

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 $1550.00 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 13, 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.