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
Trenton D. Weeks, DC

Respondent Name
Hartford Insurance Company of the Midwest

MFDR Tracking Number
M4-15-0386-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
September 25, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On 11/19/2013 I performed an evaluation to determine maximum medical improvement and impairment of the …claimant. I performed this examination at the request of the injured employee and the treating doctor.

05/20/2014 Carrier EOR indicates code:

- No EOR has been received. Carrier is unable to send EOR after multiple requests.

Response: This examination was performed for the purpose of determining MMI and Impairment as it related to the work injury of [redacted] This evaluation addresses compensable body parts and not specific diagnoisis. After careful review of documentation it is concluded that this billed examination was properly performed, document, and submitted. This examination and report in no way constitutes treatment and was referred by the treating doctor.

Carrier is unable to send proper EOR which clearly states codes/ reasons for denied payment.

This billed examination has been outstanding since 11/19/2013 without an appropriate EOR when requested multiple times. This is the 3rd attempt at resolving this claim.

11/24/2013-Report of MMI/IR examination was sent via fax to carrier.
12/03/2013-Billed examination was sent to carrier via fax.
02/03/2014-Request for Bill Status was sent to carrier via fax

- There has been no response from carrier concerning this claim.

We have not received original review/EOR. Please provide the status of this bill immediately.

This report and bill was performed according to TDWC rules and should be paid in full. Insurance carrier is required by the 28 Texas Administrative code, chapter 133, RULE §133.240 (H) to provide an explanation of the reason for reduction/denial.

08/05/2014 Carrier EOR indicates code:

- No EOR has been received on Reconsideration. Carrier is unable to send EOR after multiple requests.

Response: This is a request for the services of the Texas Department of Insurance for medical fee dispute resolution as this billed examination has been outstanding since 11/19/2013. This examination was performed for the purpose of determining MMI and Impairment as it related to the work injury of 11/28/2011. This evaluation addresses compensable body parts and not specific diagnosis. Again, after careful review of documentation it is concluded that this billed examination was properly preformed, document, and submitted within the allotted time for medical bill submission and reconsideration.

Carrier is unable to send proper EOR which clearly states codes/ reasons for denied payment.

11/24/2013- Report of MMI/IR examination was sent via fax to carrier.

12/03/2013- Billed examination was sent to carrier via fax.

02/03/2014- Request for Bill Status was sent to carrier via fax.

- There has been no response from carrier concerning this claim.

07/18/2014- Request for Bill Status for Reconsideration was sent to carrier via fax.

- There has been no response from carrier concerning this claim.

This billed examination has been sent to carrier multiple times within the allotted time for submission. I have included copies of the original bill (with conformations) and request for Reconsideration. This report and bill was performed according to TDWC rules and should be paid in full."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In response to the disput e for Medical Fee, please be advised in review of our file we have determined that this bill was never received by CCMSI.

It is our position that this fee is not owed as this employee was certified at MMI on 1-11-12 and had an alternative impairment rating exam on 6-25-13 so this bill for a third rating is not medically reasonable or necessary."

Response Submitted by: Cannon Cochran Management Services, Inc., PO Box 802082, Dallas, TX 75380

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 19, 2013	99456	$350.00	$350.00

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 sets out medical bill submission procedures for health care providers.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. 28 Texas Administrative Code §134.204 sets out the procedures for billing and reimbursing examinations of maximum medical improvement and impairment rating.
5. Texas Labor Code §408.123 provides law regarding certification of maximum medical improvement and impairment rating.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   No explanation of benefits was received with this dispute.

Issues

1. Did the requestor file a complete bill within the time frame required by 28 Texas Administrative Code §133.20?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.

   28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise,

written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission."

Review of the submitted documentation indicates that the requestor successfully faxed a billed with the required documentation for the services in question on December 3, 2013. Therefore, the Division finds that the requestor did file a complete bill within the time frame required by 28 Texas Administrative Code §133.20.

2. In the position statement, the insurance carrier states, "It is our position that this fee is not owed as this employee was certified at MMI on 1-11-12 and had an alternative impairment rating exam on 6-25-13 so this bill for a third rating is not medically reasonable or necessary." Texas Labor Code §408.123 (h) states, "If an employee's disputed certification of maximum medical improvement or assignment of impairment rating is finally modified, overturned, or withdrawn, **the first certification or assignment made after the date of the modification, overturning, or withdrawal** becomes final if the certification or assignment is not disputed before the 91st day after the date notification of the certification or assignment is provided to the employee and the carrier by verifiable means. A certification or assignment may be disputed after the 90th day only as provided by Subsection (f)" [emphasis added]. This indicates that the mere presence of a designated doctor's certification of maximum medical improvement and an alternate certification do not preclude the necessity of another certification. Therefore, the Division finds that the requestor is entitled to reimbursement of $350.00 for the examination of maximum medical improvement, as defined by 28 Texas Administrative Code §134.204 (j)(2)(A) and (j)(3)(C).

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 $350.00.

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 $350.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	January 13, 2015
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 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.