



/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

Marcus P. Hayes, DC

Respondent Name

Texas Council of Risk Management

MFDR Tracking Number

M4-15-0822-01

Carrier's Austin Representative

Box Number 43

MFDR Date Received

November 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I submitted a properly completed, properly documented claim to Texas Council Risk Management Fund. No payment nor EOB was received. A 'Request for Reconsideration/Past Due Notification' letter was then faxed on 09/09/2014, however, the IC failed to respond per DWC Rule 133.250 (f).

Position Statement:

The IC has received this claim on two separate occasions. The first submission was received via regular mail and the second via fax. The IC has not responded to either submission. Therefore, AI&FATC requests that Broadspire/American Zurich remit the balance due of **\$350.00** plus interest for said procedure performed on said patient on said date."

Amount in Dispute: \$350.00

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 on November 12, 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
July 16, 2014	99456-NM	\$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 §134.204 sets out the fee guidelines for Division specific codes.
3. 28 Texas Administrative Code §133.10 sets out the procedures for billing by a health care provider.
4. 28 Texas Administrative Code §133.250 sets out the procedures for requests for reconsideration.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
No EOBs received with submitted documentation.

Issues

1. What is the total allowable for the services in dispute
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(2)(A) states, "If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added." Further, per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350."
The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement finding that the injured employee had not reached MMI. Therefore, the correct MAR for this examination is \$350.00.
2. Review of the submitted documentation finds that an initial bill was successfully submitted electronically on 7/17/14 and a follow-up request was successfully faxed on 9/9/14 according to 28 Texas Administrative Code §133.10 and §133.250 (c)(2). The evidence does not support payment or denial has been made by the insurance carrier. Therefore, the requestor is entitled to reimbursement of \$350.00.

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 \$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

		January 27, 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.