



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Gregory P. Ennis, MD, PA

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-15-2053-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

March 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On July 23, 2014 workers compensation specific services were provided in the form of a Designated Doctor examination to determine Maximum Medical Improvement and assign an impairment rating, determine Extent of Injury, and address Return to Work..."

On July 15, 2014 EcCare Health Centers did submit a completed CMS 1500 claim form and a DWC69 with narrative report to Texas Mutual, particularly one Patanya R Johnson, adjuster of record, as evidenced by the facsimile and Email transmission logs enclosed.

Per rule 133.210 'Medical Documentation' paragraph (e); '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.'

Texas Mutual multiple denial reasons are in err.

On December 30, 2014 EcCare Health Center did request the carrier to reconsider the decision under 133.250 as evidenced by documentation enclosed.

EcCare Health Centers recognizes and correctly reads TAC 28 part 2 134.204 demonstrating that reimbursement in the amount of \$1,890.00 is due and payable, and interest due on this bill per rule 134.130 of TAC 28 part 2."

Amount in Dispute: \$1890.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 7/23/2014.

The requestor billed MMI/IR, Extent of Injury, Return to Work, and Disability exams. The date for these listed on the requestor' bill is 7/23/14. The exam date listed on the requestor's narrative report and the DWC69 is 7/15/14. Texas Mutual declined to issue payment absent documentation supporting the services billed.

The requestor states, '...A designated doctor who examines an injured employee pursuant **to any question relating to return to work is required to file a Work Status Report** that meets the required elements of these reports as described in 129.5 of this title...' Rule 129.5(c) indicates the report shall be signed. Review of the report shows no signature by the designated doctor. No payment is due for the Work Status Report."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2014	Designated Doctor Examination (MMI/IR/RTW/EOI/Disability) & Work Status Report	\$1890.00	\$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 §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
3. 28 Texas Administrative Code §129.5 provides procedures for Work Status Reports.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
 - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
 - 249 – DWC-73 not submitted; not properly completed and/or missing doctors signature; reimbursement denied per Rule 129.5.
 - 892 – Denied in accordance with DWC Rules and/or Medical Fee Guideline including current CPT Code descriptions/instructions.
 - CAC-18 – Exact duplicate claim/service
 - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 878 – Appeal (request for reconsideration) previously processed. Refer to Rule 133.250(H)
 - 891 – No additional payment after reconsideration

Issues

1. Are the disputed services supported according to 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. The dispute involves a Designated Doctor Examination for date of service July 23, 2014, including Maximum Medical Improvement, Impairment Rating, Disability as a Direct Result, Return to Work, use of specialist reports, and a Work Status Report. 28 Texas Administrative Code §134.204 (j)(1)(D) requires a report filed to support billing for Maximum Medical Improvement and Impairment Rating. 28 Texas Administrative Code §134.204 (k) requires reporting to support the billing of Return to Work and Evaluation of Medical Care examinations.

Review of the submitted documentation finds that the only reports and narrative provided are for and examination performed on date of service July 15, 2014. Therefore, these services were not supported according to 28 Texas Administrative Code §134.204.

Per 28 Texas Administrative Code §134.204 (l), "The following shall apply to Work Status Reports. When billing for a Work Status Report **that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section** [emphasis added], refer to §129.5 of this title (relating to Work Status Reports)".

Therefore, the filing of the DWC-073 is not payable when provided in conjunction with a Designated Doctor Examination under 28 Texas Administrative Code §134.204 (i). Further, submitted documentation did not include a Work Status Report. For this reason, this service was not supported according to 28 Texas Administrative Code §134.204

2. Because the disputed services were not supported as required by 28 Texas Administrative Code §134.204, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional 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

	Laurie Garnes	April 21, 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.