



# 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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

DAVID WOOD, MD

**Respondent Name**

CITY OF SAN ANTONIO

**MFDR Tracking Number**

M4-15-3046-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

MAY 19, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "our claim and requests for reconsideration are being denied based on our provider not eligible to perform services billed."

**Amount in Dispute:** \$730.03

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The enclosed Commissioner of Workers' Compensation Order indicates the request to change treating doctors from Dr. Christine Ann Contreras to Dr. Lunke was denied on 12/08/14, 01/14/2015 and 02/10/2015. Therefore, the bills were correctly denied with ANSI code 185D."

**Response Submitted by:** Argus Services Corporation

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2014	CPT Code 73721 MRI Lower Extremity	\$372.88	\$0.00
December 16, 2014	CPT Code 72148-AQ MRI Spine	\$357.15	\$0.00
TOTAL		\$730.03	\$0.00

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §180.22, effective January 9, 2011 requires the treating doctor to coordinate the claimant's health care.

3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for professional services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 185D-The rendering provider is not eligible to perform the service billed. \*Provider is not the claimant's treating doctor, and does not appear to have been referred by the claimant's treating doctor.\*
  - W3W-No reimbursement recommended on reconsideration. Previous recommendation was in accordance with the Workers' Compensation State Fee Schedule.

**Issues**

Is the disputed service recommended by the treating doctor? Is the requestor entitled to reimbursement?

**Findings**

The insurance carrier denied disputed services with claim adjustment reason code "185D." The respondent contends that "The enclosed Commissioner of Workers' Compensation Order indicates the request to change treating doctors from Dr. Christine Ann Contreras to Dr. Lunke was denied on 12/08/14, 01/14/2015 and 02/10/2015."

On February 12, 2015, an agreement was reached to allow claimant to change treating doctors from Dr. Christine Ann Contreras to Dr. Roger Lunke.

28 Texas Administrative Code §180.22(c) states "The treating doctor is the doctor primarily responsible for the efficient management of health care and for coordinating the health care for an injured employee's compensable injury. The treating doctor shall: (1) except in the case of an emergency, approve or recommend all health care reasonably required that is to be rendered to the injured employee including, but not limited to, treatment or evaluation provided through referrals to consulting and referral doctors or other health care providers, as defined in this section."

The Division reviewed the submitted medical bill and referral for treatment that indicates the referring doctor was Dr. Lunke. Because Dr. Lunke was not the treating doctor on the disputed date of service, the referral for the MRIs were not in accordance with 28 Texas Administrative Code §180.22(c). As a result, 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**

		06/25/2015
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, 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 MFDR 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.**