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
Jared Rosenberg, D.C.

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-15-3397-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 12, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "NO RESPONSE TO BILLING"

Amount in Dispute: $850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the attached EOR showing payment of $685.88."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 4, 2014	Designated Doctor Examination (MMI/IR/RTW)	$850.00	$850.00

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
3. 28 Texas Administrative Code §133.250 sets out the procedures for requests for reconsideration.
4. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   No Explanation of Benefits for the disputed services was submitted.

Issues

1. Were the disputed services denied in accordance with 28 Texas Administrative Codes §§133.240 and 133.250?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The services in dispute are regarding a Designated Doctor Examination to determine Maximum Medical Improvement, Impairment Rating, and the ability of the injured employee to Return to Work. 28 Texas Administrative Code §133.240 (a) states, "An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation."

   Further, 28 Texas Administrative Code §133.250 (g) states, in relevant part, "The insurance carrier shall take final action on a reconsideration request within 30 days of receiving the request for reconsideration…" The requestor's position is that they received no response to billing. Documentation supports that the initial bill was submitted on September 12, 2014 and a request for reconsideration was submitted on November 21, 2014, stating that no response to the initial bill was received within 50 days, in accordance with 28 Texas Administrative Code §133.250 (c).

   The insurance carrier did not refute the requestor's position, but submitted an explanation of benefits for services that were not included in the dispute. Therefore, the Division finds that the disputed services were not denied in accordance with 28 Texas Administrative Codes §§133.240 and 133.250 and will be reviewed in accordance with the appropriate fee guidelines.

2. 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 as ordered by the Division. Therefore, the correct MAR for this examination is $350.00. The provider stated, "The examinee has not reached Maximum Medical Improvement; therefore, no impairment could be rendered at this time" (p. 5). For this reason, no MAR is assigned for Impairment Rating on this examination.

   Per 28 Texas Administrative Code §134.204 (k), "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee." The submitted documentation indicates that the Designated Doctor performed an examination to determine the injured employee's ability to Return to Work. Therefore, the correct MAR for this examination is $500.00.

3. The total MAR for the disputed services is $850.00. The insurance carrier paid $0.00. Therefore, a reimbursement of $850.00 is recommended.

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 $850.00.

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 $850.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	July 15, 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.