



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

Charlotte Burgess, D.C.

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-16-0005-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 1, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The claim was not paid in full."

Amount in Dispute: \$337.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company has determined additional monies are owed in the amount of \$4.37. Interest in the amount of \$4.37 has been issued."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 13, 2015	Designated Doctor Examination (EOI)	\$337.50	\$337.50

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 §133.10 provides the requirements for a complete medical bill.
- 28 Texas Administrative Code §133.210 provides the procedures for submitting medical documentation with medical bills.
- 28 Texas Administrative Code §127.220 sets out the requirements for designated doctor reports.
- 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 16 – "CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION." 28 Texas Administrative Code §133.10 provides the requirements for a complete medical bill. Review of the submitted information finds that the medical documentation and reports required by 28 Texas Administrative Codes §§127.220 and 133.210. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. 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.

Furthermore, 28 Texas Administrative Code §134.204 (i)(2) states,

When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection:

- (A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section;
- (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and
- (C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section.

The submitted documentation indicates that the Designated Doctor performed an examination to determine Extent of Injury. Documentation supports that this was the only RTW/EMC examination ordered for the date of service in question. Therefore, the correct MAR for this examination is \$500.00.

3. The total MAR for the disputed service is \$500.00. The insurance carrier paid \$162.50. An additional reimbursement of \$337.50 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 \$337.50.

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 \$337.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

September 30, 2015
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.