



# 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**

Edward W. Smith, D.O.

**Respondent Name**

Arch Insurance Company

**MFDR Tracking Number**

M4-16-1235-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

January 11, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "NO EOB WAS EVER RECEIVED."

**Amount in Dispute:** \$650.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on January 21, 2016. 28 Texas Administrative Code §133.307(d)(1) requires that:

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 a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 18, 2015	Designated Doctor Examination	\$650.00	\$650.00

#### 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 §102.4 sets out the procedures for non-division communications.
3. 28 Texas Administrative Code §133.20 sets out the procedures for submission of a medical bill.

4. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
5. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
6. Submitted documentation does not include explanations of benefits for the services in question.

### Issues

1. Did the requestor submit a medical bill in accordance with 28 Texas Administrative Code §133.20?
2. What is the maximum allowable reimbursement (MAR) for the services in question?
3. Is the requestor entitled to reimbursement for the services in question?

### Findings

1. 28 Texas Administrative Code §133.20 states, in relevant part,
  - (a) The health care provider shall submit all medical bills to the insurance carrier except when billing the employer in accordance with subsection (j) of this section.
  - (b) Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided...

28 Texas Administrative Code §102.4(h) states,

Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:

- (1) the date received, if sent by fax, personal delivery or electronic transmission or,
- (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of **the signature date on the written communication** [emphasis added] or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

Review of the submitted documentation finds that the great weight of evidence supports that the requestor submitted a medical bill in accordance with 28 Texas Administrative Code §133.20.

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 supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is \$350.00.

Per 28 Texas Administrative Code §134.204(j)(4), "The following applies for billing and reimbursement of an IR evaluation. ... (C)(ii) The MAR for musculoskeletal body areas shall be as follows. ... (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area." The submitted documentation supports that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the left wrist. Therefore, the correct MAR for this examination is \$300.00.

3. 28 Texas Administrative Code §133.240(a) requires that

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.

Submitted documentation does not support that the insurance carrier denied the services in question in accordance with 28 Texas Administrative Code §133.240(a), the requestor is entitled to reimbursement of those services. The total MAR for the services in question is \$650.00. The insurance carrier paid \$0.00. A reimbursement of \$650.00 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 \$650.00.

**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 \$650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

_____	<u>Laurie Garnes</u>	<u>March 14, 2016</u>
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.**