



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

Juan F. Quiroz, M.D.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-16-1256-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

January 12, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier denied the first bill submission (date of audit 05/04/2015) stating the claim lacked information or billing errors and the documentation submitted does not support the service billed. A corrected claim was sent 05/15/2015 ... which they marked as received 06/17/2015. However, there was a second denial sent 06/10/2015 which now states there are different billing errors. A final EOB with a 08/03/2015 Date of Audit was then sent stating the time limit had expired, however, there was no additional reconsideration/corrected claim sent after the 06/10/2015 EOB issued by Texas Mutual Insurance."

Amount in Dispute: \$950.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The initial bill Texas Mutual received ... listed date 3/9/15 while the DWC69 and Narrative Report listed the date as 3/12/15. Texas Mutual declined to issue payment absent consistency in the dates.

The requestor submitted a 'corrected claim' that Texas Mutual received 5/15/15... The date on the bill was 9/9/15. Texas Mutual explicitly stated on the EOB the problem:

DATE OF EXAM ON REPORT AND DWC69 IS 3/12/15. DATES DON'T MATCH DATE OF SERVICE BILLED IS 3/9/15.

The requestor submitted a second corrected bill with the correct date on it... Texas Mutual received this bill on 6/26/15. Absent timely bill submission Texas Mutual declined to issue payment."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 12, 2015	Designated Doctor Examination	\$950.00	\$950.00

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 §133.20 sets out the procedures for submitting medical bills.
3. 28 Texas Administrative Code §133.250 sets out the procedures for reconsideration of medical bills.
4. 28 Texas Administrative Code §102.4 provides the general rules for non-commission communications.
5. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – The time limit for filing has expired.
 - 731 – Per 133.20(b) provider shall not submit a medical bill later than the 95th day after the date the service.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to reimbursement for the services in question?

Findings

1. The services in this dispute involve a designated doctor examination to determine if the injured employee has reached maximum medical improvement, and if so, the impairment rating (99456-W5-WP), for date of service March 12, 2015. The insurance carrier denied disputed services with claim adjustment reason codes 29 – "THE TIME LIMIT FOR FILING HAS EXPIRED," and 731 – "PER 133.20(B) PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE."

28 Texas Administrative Code §133.20 states, in relevant part, "Except as provided in Labor Code §408.0272(b), (c) or (d), a health care provider shall not **submit** [emphasis added] a medical bill later than the 95th day after the date the services are provided..." Further, 28 Texas Administrative Code §133.250(d)(1) requires that a written request for reconsideration shall "reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill."

28 Texas Administrative Code §102.4(h) states, in relevant part, "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..."

Review of the submitted documentation supports that a medical bill for the disputed services was **submitted** to the insurance carrier by fax on May 15, 2015. 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(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.

This dispute involves a Designated Doctor Impairment Rating (IR) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4), which states that:

- (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
 - (i) Musculoskeletal body areas are defined as follows:
 - (I) spine and pelvis;
 - (II) upper extremities and hands; and,
 - (III) lower extremities (including feet).
 - (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; and
 - (-b-) \$150 for each additional musculoskeletal body area.

(D) ...

- (i) Non-musculoskeletal body areas are defined as follows:
 - (I) body systems;
 - (II) body structures (including skin); and,
 - (III) mental and behavioral disorders.
- (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides...
- (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.

Review of the submitted documentation finds that the requestor performed impairment rating evaluations of the head, in the nervous system; skin, a body structure; lower extremities; and one upper extremity. Therefore, the correct MAR for this examination is \$750.00, as shown in the table below:

Examination	AMA Chapter	\$134.204 Category	Reimbursement Amount
Maximum Medical Improvement			\$350.00
IR: Left Elbow (ROM)	Musculoskeletal System	Upper Extremities	\$300.00
IR: Left Knee (ROM)		Lower Extremities	\$150.00
IR: Right Knee (ROM)			
IR: Right Ankle (ROM)			
IR: Lacerations	Skin	Body Structures	\$150.00
IR: Head injury	Nervous System	Body Systems	\$150.00
Total MMI			\$350.00
Total IR			\$750.00
Total Exam			\$1,100.00

3. The total MAR for the disputed services is \$1100.00. The requestor is seeking \$950.00. The insurance carrier paid \$0.00. A reimbursement of \$950.00 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 \$950.00.

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 \$950.00 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

January 29, 2016
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.