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
Howard L. Dillard, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-2255-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE INITIAL DIAGNOSIS WAS CORRECT. V49.6 IS UNSPECIFIED UPPER LIMB AMPUTATION."

Amount in Dispute: $515.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual received the bill on 8/28/15, reviewed it, determined the diagnosis code of V49.6 was invalid, and returned the bill on 9/4/15 along with a cover letter to the requestor explaining this… Because of the invalid diagnosis code, the bill was incomplete.

Texas Mutual received a complete bill by fax from the requestor on 2/10/16… Because the faxed date is deemed the received date, Rule 102.4(p), Texas Mutual declined to issue payment absent timely bill submission."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 8, 2015	Designated Doctor Examination	$515.00	$500.00

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 §133.10 sets out the requirements for completing medical bills.
3. 28 Texas Administrative Code §133.20 sets out the procedures for submitting medical bills.
4. 28 Texas Administrative Code §133.200 defines the actions of an insurance carrier regarding receipt of medical bills.

5. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
6. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
7. Texas Labor Code §408.027 sets out the requirements for payment of medical bills.
8. Texas Labor Code §408.0041 sets out the requirements relating to Designated Doctor Examinations.
9. Texas Government Code §311.016 defines certain terms for code construction.
10. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - CAC-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. Did the insurance carrier return the initial medical bill submission in accordance with 28 Texas Administrative Code §133.200?
2. Are the insurance carrier's reasons for denial of payment supported?
3. What is the maximum allowable reimbursement (MAR) of the disputed services?
4. Is the requestor entitled to reimbursement of the disputed services?

Findings

1. The disputed services include a designated doctor examination to determine the injured employee's ability to return to work and a Work Status Form (DWC073) for date of service August 8, 2015. Texas Labor Code §408.0041(h) states that "The insurance carrier shall pay for: (1) an examination required under Subsection (a), (f), or (f-2), unless otherwise prohibited by this subtitle or by an order or rule of the commissioner…"

   Review of submitted documentation finds that a medical bill for the disputed services was submitted on August 26, 2015. The insurance carrier returned this medical bill to the requestor as incomplete. 28 Texas Administrative Code §133.200(a) states,

   > Upon receipt of medical bills submitted in accordance with §133.10(a)(1) and (2) of this chapter (relating to Required Medical Forms/Formats), an insurance carrier shall evaluate each medical bill for completeness as defined in §133.2 of this chapter (relating to Definitions).
   > (1) Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill.

   28 Texas Administrative Code §133.2 defines a complete medical bill as:

   > A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter (relating to Required Billing Forms/Formats), or as specified for electronic medical bills in §133.500 of this chapter (relating to Electronic Formats for Electronic Medical Bill Processing).

   Review of the submitted documentation finds that the requestor met the requirements of a complete medical bill. For this reason, the division finds that the insurance carrier did not return the initial medical bill submission in accordance with 28 Texas Administrative Code §133.200.

2. The insurance carrier denied disputed services with claim adjustment reason codes CAC-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." Texas Labor Code §408.027(a) states,

   > A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.

   Review of the submitted information finds that the requestor submitted the initial medical bill on August 26, 2015. This is prior to the 95th day after the date of service. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

3. 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 ability of the injured employee to return to work. Therefore, the correct MAR for this examination is $500.00.

Per 28 Texas Administrative Code §134.204(l),

> The following shall apply to Work Status Reports. When billing for a Work Status Report **that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section** [emphasis added], refer to §129.5 of this title (relating to Work Status Reports).

Therefore, the filing of the DWC-073 is not separately payable when provided in conjunction with a Designated Doctor Examination performed according to 28 Texas Administrative Code §134.204(i).

4. The total MAR for the disputed services is $500.00. The insurance carrier paid $0.00. A reimbursement of $500.00 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 $500.00.

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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 20, 2016
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.