



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

Richard Lawrence, M.D.

Respondent Name

American Zurich Insurance Company

MFDR Tracking Number

M4-16-2328-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

April 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: \$850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "To date, Corvel has not received this bill from the Requestor for review."

Response Submitted by: Corvel

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: September 25, 2015, Designated Doctor Examination, \$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 §133.20 sets out the procedures for submission of a medical bill.
3. 28 Texas Administrative Code §133.210 provides the guidelines for documentation requirements for medical bills.
4. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
5. 28 Texas Administrative Code §133.250 sets out the procedures for reconsideration of a medical bill.
6. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.

7. The submitted documentation does not include an explanation of benefits.

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 for the disputed services?
3. Is the requestor entitled to reimbursement of the disputed services?

Findings

1. The procedures for submitting a medical bill to the insurance carrier are set out in 28 Texas Administrative Code §133.20. Review of the available information finds that the requestor submitted a medical bill to the insurance carrier on October 2, 2015 and December 11, 2015.

The respondent argued that the insurance carrier did not receive a copy of the medical bill in question. 28 Texas Administrative Code §133.210(e) states, "It is the insurance carrier's obligation to furnish its agents with any documentation necessary for the resolution of a medical bill. The Division considers any medical billing information or documentation possessed by one entity to be simultaneously possessed by the other." Review of the submitted documentation finds that an agent of the insurance carrier received the medical bill in question. The division finds 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)(2)(A),

If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added.

Paragraph (3) states, "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 MMI and found that the injured employee was not at MMI. Therefore, the correct MAR for this examination is \$350.00.

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...

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.

3. The total MAR for the disputed services is \$850.00. The insurance carrier paid \$0.00. 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 in 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

_____	<u>Laurie Garnes</u>	<u>May 12, 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.