TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
GREGORY P. ENNIS, MD

Respondent Name
CASTLEPOINT NATIONAL INSURANCE COMPANY

MFDR Tracking Number
M4-16-3360-02

Carrier's Austin Representative
Box Number 17

MFDR Date Received
July 5, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On September 7, 2015 EcCare Health Centers did submit a complete CMS 1500 form and required DWC forms and narrative to the carrier as demonstrated by the enclosed facsimile receipt."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent's first receipt of the medical bill in dispute was this DWC-60. . . . Requestor's documentation shows they submitted their medical bill to [address of third party]. This is not the proper mailing address of the Respondent. . . . Further, Requestor contends they faxed the medical bill to [fax number of third party]. This was not a working number for Respondent at the time of billing which is evident by the documentation as there is no confirmation the fax went through."

Response Submitted by: Downs Stanford, PC

SUMMARY OF FINDINGS

Date of Service	Disputed Services	Amount In Dispute	Amount Due
September 3, 2015	Referral doctor examination to determine extent of the compensable injury — billed under procedure code 99456-RE	$500.00	$0.00

FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent. 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 §102.4 sets out general rules regarding communications.
2. 28 Texas Administrative Code §133.20 sets out procedures for medical bill submission by a health care provider.
3. 28 Texas Administrative Code §133.210 sets out provisions regarding processing of medical documentation.
4. 28 Texas Administrative Code §133.250 sets out procedures for reconsideration of payment for medical bills.
5. 28 Texas Administrative Code §133.305 sets out general provisions regarding medical dispute resolution.
6. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
7. Neither party to this dispute submitted copies of explanations of benefits for consideration in this review.

Issues

1. Has the requestor supported that the medical bills were submitted to the insurance carrier?
2. Are the medical fee issues eligible for review?

Findings

1. This dispute regards an unpaid medical bill for a referral examination from the treating doctor to determine the extent of the compensable injury for an injured employee.

   The requestor submitted medical bills, requested reconsideration, and receiving no response from the insurance carrier has requested medical fee dispute resolution.

   The respondent asserts that it has not received the bills for review prior to the request for medical fee dispute resolution.

   28 Texas Administrative Code §133.20(a) requires that the health care provider shall submit all medical bills to the insurance carrier (except when billing the employer).

   28 Texas Administrative Code §133.250(a) provides that if the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action.

   Rule §133.250(i) further provides that if the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Title 28 Texas Administrative Code, Chapter 133, Subchapter D (relating to dispute of medical bills).

   The non-division communications rule at 28 Texas Administrative Code §102.4(h) states that, 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 or the date it was received minus five days.

   28 Texas Administrative Code §133.210(e) states that "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."

   The requestor states in their position statement, "EcCare Health Centers did submit a complete CMS 1500 form and required DWC forms and narrative to the carrier as demonstrated by the enclosed facsimile receipt." Review of the submitted "Patient Inquiry/Edit" document finds no confirmation that a facsimile was received. The document does not indicate the number of pages sent or that any pages were successfully transmitted to completion. The respondent states that the fax-number was not a working number of the insurance carrier on the date of transmission. Based on the submitted information, a receipt date cannot be established per §102.4(h)(1) for fax or electronic transmission.

The submitted information supports that paper medical bills were mailed. Documentation was not provided to support a postmark date. The respondent asserts that no bills were received by mail, and no documentation was presented by the requestor to support mail receipt by the insurance carrier. Although a signature date of September 7, 2015 is found on the medical bill—sufficient to support a sent date of September 7, 2015—the respondent asserts that the address on the bills "is not the proper mailing address of the Respondent."

The respondent asserts the correct address(es) are shown on a submitted explanation of benefits (EOB) showing payment to the health care provider for services rendered by the provider to the same injured employee regarding an earlier date of service (which is not disputed). The explanation of benefits indicates a different claims mailing address and check issuing address (both located in different cities).

Comparing the mailing address on the medical bill to the submitted EOB finds that the mailing address on the bill does not match either of the current addresses listed for the insurance carrier on the sample EOB. The requestor did not present documentation verifying the address where it had sent the medical bill. Accordingly, the requestor has not supported by a preponderance of the evidence that the medical bill was sent to a valid address for the insurance carrier—or an agent of the insurance carrier, sufficient to meet the requirements of the Division's simultaneous possession rule in §133.210(e), above.

The Division therefore concludes that the requestor has failed to support that the bills were presented to the insurance carrier for review or reconsideration after final action before requesting medical fee dispute resolution.

2. A medical fee dispute is defined in 28 Texas Administrative Code §133.305(a)(4) as:

> A dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury. The dispute is resolved by the division pursuant to division rules, including §133.307 of this title (relating to MDR of Fee Disputes). The following types of disputes can be a medical fee dispute:
>
> > (A) a health care provider . . . dispute of an insurance carrier reduction or denial of a medical bill; . . .
> >
> > (C) a health care provider dispute regarding the results of a division or insurance carrier audit or review which requires the health care provider to refund an amount for health care services previously paid by the insurance carrier.

The insurance carrier did not reduce or deny the medical bill and did not have the opportunity to do so prior to the request for medical fee dispute resolution. This dispute does not therefore meet the definition of a medical fee dispute under §133.305. Consequently, there are no medical fee issues eligible for review.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the amended findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, it was determined that the requestor is not entitled to reimbursement. Pursuant to a grant of authority by the Commissioner of Workers' Compensation to issue, amend or withdraw medical fee dispute resolution findings, decisions and orders, the respondent is hereby ordered to pay $0.00 reimbursement to the requestor for the services in dispute.

Authorized Signature

	Grayson Richardson	August 26, 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.