



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

J. Scott Harris, D.C.

Respondent Name

Federal Insurance Company

MFDR Tracking Number

M4-16-3477-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

July 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Within the seven-day requirement, all parties including Ms. Tandy Lyon, were provided a copy of the report electronically. In the case of Ms. Lyon, she was provided a copy of the report and the billing for the services she ordered. Nine pages were confirmed as successfully received on 9/1/15 at 15:09hrs by the transmission verification report (please see fax cover sheet). When we called to verify by phone receipt of the report and bill, we were asked in addition to Ms. Lyon, that the insurance carrier's authorized agent company listed on the DWC-32, IMED, receive a copy also. We were instructed to send it to their adjuster, Verdina Sellers, at (214) 380-5015. She, too, was sent electronically a copy of the bill and report on 9/1/15 at 16:57hrs (please see transmission verification report showing nine pages successfully received)."

Amount in Dispute: \$800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bill in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 26, 2015	Designated Doctor Examination	\$800.00	\$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 §133.10 sets out the procedures for completing a medical bill.
3. 28 Texas Administrative Code §133.20 sets out the procedures for submission of medical bills.
4. 28 Texas Administrative Code §133.210 sets out the procedures for documentation associated with medical bills.
5. 28 Texas Administrative Code §133.240 sets out the procedures for payment and denial of medical bills.
6. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
7. Texas Labor Code §408.027 defines the requirements for payment of a health care provider.
8. The submitted documentation did not include explanations of benefits for the services in question.

Issues

1. Were the services in question paid or denied in accordance with 28 Texas Administrative Code §133.240?
2. What is the recommended reimbursement for the disputed services?

Findings

1. The requestor states in their position statement that they have not received a response to billing for the services in question. The documentation submitted by Dr. J. Scott Harris includes the following:
 - A fax confirmation sheet, dated September 1, 2015, indicating that the medical bill and report for the services in question were successfully submitted to the adjuster for the insurance carrier at the fax number listed on the Request for Designated Doctor Examination (DWC032).
 - A fax confirmation sheet, dated September 1, 2015, indicating that the medical bill and report for the services in question were successfully submitted to the bill review agent at the fax number listed on the DWC032.

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.

The division concludes that Federal Insurance Company received the medical bill for the service in dispute on September 1, 2015.

Per Texas Labor Code Sec. 408.027 (b), Federal Insurance Company was required to pay, reduce or deny the disputed services not later than the 45th day after it received the medical bill from Dr. J. Scott Harris. Corresponding 28 Texas Administrative Code §133.240 also required Federal Insurance Company to take final action by issuing an explanation of benefits not later than the statutorily-required 45th day.

Federated Insurance Company was therefore required to take the following actions in accordance to 28 Texas Administrative Code §133.240:

- (a) An insurance carrier **shall take final action** [emphasis added] after conducting bill review on a complete medical bill...**not later than the 45th day** [emphasis added] after the insurance carrier received a complete medical bill...
- (e) The insurance carrier **shall send the explanation of benefits** [emphasis added] in accordance with the elements required by §133.500 and §133.501 of this title...The explanation of benefits shall be sent to:
 - (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill...

Review of the submitted documentation does not find an explanation issued by the insurance carrier for the services in question. Therefore, the division finds that the services in question were not paid or denied in accordance with 28 Texas Administrative Code §133.240.

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 maximum allowable reimbursement (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) 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.
 - (-b-) \$150 for each additional musculoskeletal body area.

The submitted documentation indicates that the requestor provided an impairment rating and performed a full physical evaluation with range of motion for the upper extremities. Therefore, the correct MAR for this examination is \$300.00.

The total MAR for the disputed services is \$650.00. This is the amount 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 on the submitted information, pursuant to Texas Labor Code Sec. 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 \$650.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	August 31, 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.