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
Liza Leal, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-17-0955-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
December 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The provider has attempted to submit a correct and clean bill to the carrier in a timely manner, but the carrier refuses to pay this claim. The provider requests payment in the amount of $850.00 for the above date of service."

Amount in Dispute: $850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of **9/2/2016**. The requestor billed 99456-W5/NM and 99456-W8/RE. The date on the bill is 9/2/16 … The date of the exam on the DWC69 form is 9/23/16. More importantly, the date on the narrative report is also 9/23/16. Because of this inconsistency Texas Mutual declined to issue payment as the date of the billing is not supported by the documentation."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 23, 2016	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 §133.2 provides definitions for terms used related to the processing of medical bills.
3. 28 Texas Administrative Code §133.10 sets out the requirements for a complete medical bill.

4. 28 Texas Administrative Code §133.200 sets out the procedures for review of a medical bill.
5. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine issues of return to work with dates of service on or after September 1, 2016.
6. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating with dates of service on or after September 1, 2016.
7. Texas Labor Code §408.0041 provides the requirements for designated doctor examinations.
8. The submitted documentation did not include an explanation of benefits for the date of service in question.

Issues

1. What are the services considered for this dispute?
2. Did Texas Mutual return the medical bill in question in accordance with 28 Texas Administrative Code §133.200?
3. What is the maximum allowable reimbursement (MAR) for the services in question?
4. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. Per the Medical Fee Dispute Resolution Request (DWC060) received by the division on December 6, 2016, Liza Leal, M.D. is seeking reimbursement of $850.00 for a designated doctor examination that determined maximum medical improvement and the ability of the injured employee to return to work performed on September 23, 2016. These are the services considered for this dispute.

2. Documentation submitted to the division supports that a medical bill for the services in question was submitted to Texas Mutual Insurance Company (Texas Mutual) on or about October 28, 2016. Submitted documentation included a letter from Texas Mutual to Dr. Leal dated November 3, 2016 stating, "Texas Mutual Insurance Company is unable to process your bill for the reason(s) noted below: … Bill and EOB Dates of Service do not match."

   28 Texas Administrative Code §133.200 provides that an insurance carrier shall evaluate medical bills for completeness as defined by 28 Texas Administrative Code §133.2 and take the following actions within 30 days:

   - Complete the medical bill with information known to the insurance carrier, with the exceptions of dates of service, procedure codes or modifiers, number of units, and charges, or
   - Return the medical bill to the sender with a document identifying the reason(s) for returning the bill.
   - The insurance carrier may choose to contact the sender to complete the medical bill.
   - The insurance carrier "shall not return medical bills that are complete, unless the bill is a duplicate bill."

   28 Texas Administrative Code §133.2(4) 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 …, or as specified for electronic medical bills in §133.500 of this chapter …

   Review of the medical bill submitted on or about October 28, 2016 finds that it is a complete medical bill as defined by 28 Texas Administrative Code §133.2(4). The division concludes that the medical bill in question was not returned in accordance with 28 Texas Administrative Code §133.200. The services in question will be reviewed pursuant to appropriate fee guidelines.

3. Per 28 Texas Administrative Code §134.250(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 section. 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 Dr. Leal performed an evaluation of MMI and found that the injured employee was not at MMI. Therefore, the MAR for this examination is $350.00.

28 Texas Administrative Code §134.235 states, in pertinent part:

> The following shall apply to return to work (RTW)/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 maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title and shall include division-required reports…

The submitted documentation supports that Dr. Leal performed an evaluation to determine the injured employee's ability to return to work. Therefore, the MAR for this examination is $500.00.

4. Texas Labor Code §408.0041(h) requires 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

The division finds that reimbursement for the services in question was not prohibited. For this reason, Dr. Leal is eligible for reimbursement. The total MAR for the disputed services is $850.00. This amount 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 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 $850.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	December 30, 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.