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
HAND ASSOCIATES NORTH DALLAS

Respondent Name
TRAVELERS INDEMNITY COMPANY

MFDR Tracking Number
M4-17-2409-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
April 10, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[the injured employee] had to undergo emergent surgical intervention . . . due to failure of hardware. Patient external fixator . . . had failed. The failure was causing further injury . . . and was delaying healing of the previous repair. . . If the hardware was not removed it would of caused more damage and injury . . ."

Amount in Dispute: $14,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends the surgical procedure at issue was performed due to an emergency, and therefore did not require preauthorization. In support of this contention, the Provider submits a copy of the operative report, signed electronically on 10-19-2016, describing the emergency nature of the procedure. The Carrier has attached hereto the original operative report, signed electronically on 08-17-2016, and sent to the Carrier with the original billing. Comparison of the two reports will show that the Provider added sections to the 10-19-2016 report documenting the 'emergency' nature of the procedure that were not in the original 08-17-2016 report. Additionally, the Claimant was seen immediately prior to and immediately after the procedure by other physicians, none of whom document any emergency issue related to the Claimant's condition or treatment. . . . when the Provider first contacted the Carrier regarding preauthorization, the procedure was already under way. As such, no preauthorization could have been given for a procedure which had already occurred. . . . The Carrier, not knowing the procedure had already been performed, processed the preauthorization request through utilization review. The request was denied as not meeting medical necessity. That determination has never been appealed."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 12, 2016	Professional Services - Surgeon	$14,000.00	$2,155.35

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 §134.203 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.1 sets out general provisions regarding medical reimbursement.
4. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
5. 28 Texas Administrative Code §133.2 defines terms related to medical billing and processing.
6. 28 Texas Administrative Code §133.3 sets out rules for communication between providers and insurance carriers.
7. 28 Texas Administrative Code §133.240 sets out provisions regarding medical payments and denials.
8. 28 Texas Administrative Code §133.250 sets requirements for reconsideration of payment for medical bills.
9. 28 Texas Administrative Code §133.500 establishes standards and formats for electronic medical bill processing.
10. 28 Texas Administrative Code §133.501 sets out requirements for electronic medical bill processing.
11. 28 Texas Administrative Code §19.2010 sets requirements prior to issuing an adverse determination.
12. 28 Texas Administrative Code §19.2011 sets out procedures for appeal of adverse determinations.
13. Texas Labor Code §413.031 entitles health care providers to a review of services if payment is reduced or denied.
14. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
    - 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.
    - DUPL – THESE SERVICES HAVE ALREADY BEEN CONSIDERED FOR REIMBURSEMENT.
    - 38 – SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK/PRIMARY CARE) PROVIDERS.
    - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
    - TR12 – PRE-AUTHORIZATION WAS NOT OBTAINED PRIOR TO THE SERVICE/PROCEDURE BEING RENDERED.

Issues

1. Is the injured employee enrolled in a certified workers' compensation health care network?
2. Is a medical emergency supported?
3. Was preauthorization required?
4. Are there any outstanding issues of medical necessity related to the disputed medical bills?
5. Are the insurance carrier's denial reasons supported?
6. What is the applicable rule for determining reimbursement for the disputed services?
7. What is the recommended payment for the services in dispute?
8. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code: 38 – "SERVICES NOT PROVIDED OR AUTHORIZED BY DESIGNATED (NETWORK/PRIMARY CARE) PROVIDERS."

   Review of records held by the division finds no notification to the division that the insurance carrier has enrolled the injured employee in a certified workers' compensation health care network (HCN) established in accordance with Insurance Code Chapter 1305. The response does not include any documentation to support the injured employee is enrolled in a certified HCN. Review of the submitted documentation finds no information to support the health care provider had been presented such information prior to the filing of a medical fee dispute request.

   28 Texas Administrative Code §133.240(f)(15) requires that the paper form of an explanation of benefits shall include the "workers' compensation health care network name (if applicable)." The field labeled "Network Name" on the submitted explanations of benefits states "N/A." No notice was found on the EOBs that the injured employee is enrolled in a certified health care network (HCN) established in accordance with Insurance Code Chapter 1305—as required by Rule §133.240(f)(15).

   28 Texas Administrative Code §133.307(d)(2)(F) states that "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review."

As no information has been presented to MFDR regarding the injured employee's enrollment in a certified HCN, and no documentation was presented to support that the insurance carrier notified the requestor of any such participation pursuant to Rule §133.240(f)(15), the division concludes that this is not an issue in this dispute or that the respondent has waived the right to raise the issue at MFDR, per Rule §133.307(d)(2)(F).

Labor Code §413.031(a)(1) states that a health care provider is entitled to a review of a medical service provided if a health care provider is "denied payment or paid a reduced amount for the medical service rendered."

Labor Code §413.031(c) states that "in resolving disputes over the amount of payment due for services 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 commissioner rules."

The Texas Workers' Compensation Act entitles health care providers to a review of medical services if payment is denied. The Act further grants the division authority to resolve such disputes and adjudicate such payments. For these reasons, the division has jurisdiction to review the medical fee issues in this dispute.

2. The health care provider performed surgery on the injured employee. The health care provider maintains that the injured employee "had to undergo emergent surgical intervention" due to failure of external fixator hardware in order to avoid "more damage and injury."

   The respondent argues "the original operative report and contemporaneous documentation do not document the procedure was an emergency."

   Division Rule at 28 Texas Administrative Code §133.2(5)(A), defines a medical emergency as:

   > the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in:
   > (i) placing the patient's health or bodily functions in serious jeopardy, or
   > (ii) serious dysfunction of any body organ or part.

   The division notes this rule does not require the patient to actually *be* in jeopardy or *suffer* serious dysfunction. Rather, the patient must manifest acute *symptoms* of such severity (including severe pain) that the absence of immediate medical attention could *reasonably be expected* (prior to rendering services and without the benefit of hindsight) to result in serious jeopardy or dysfunction if treatment is not provided.

   The respondent states "the Claimant was seen immediately prior to and immediately after the procedure by other physicians, none of whom document any emergency issue related to the Claimant's condition." The respondent did not present any documentation to MFDR from other physicians to support this position.

   The respondent argues that the Operative Report submitted by the requestor is a later version that has been edited or altered from the original version submitted to the insurance carrier with the initial billing.

   The insurance carrier did not present documentation of Medicare payment policies or division rules or other information to support that a health care provider may not later add or edit notations to a patient's medical records in order to correct or clarify the information previously recorded.

   However, even restricting this review to the original version of the Operative Report (the version supplied by the insurance carrier), the surgeon's documentation is found sufficient to support a medical emergency.

   On the date of service, the surgeon documents several notable acute symptoms of a severe nature including:

   - complication of external static fixation device
   - traumatic rupture of volar plate of finger
   - displaced fracture of phalanx with nonunion
   - traumatic rupture of collateral ligament of finger
   - the indications section states the patient sustained a "very severe" injury of two fingers
   - now with late effects of hardware
   - Specific notations that: "the patient is aware that permanent pain, loss [of range of motion], deformity, loss of strength after fracture repair/soft tissue repair can continue due to the severity of the injury."
   - During the course of the procedure "it was noted [2 fingers] had traumatic dislocation."
   - Also: "Positive signs non-union fracture of [2 fingers] noted with external static fixator in place."

Reviewing only the surgeon's original Operative Report (submitted for review by the respondent), the division finds ample documentation of the sudden onset of medical conditions manifested by acute symptoms of sufficient severity to support that the absence of immediate medical attention could reasonably be expected to result in either serious dysfunction of the documented body parts and/or place in serious jeopardy the health or bodily functions of the injured employee.

Consequently, the division concludes an emergency was supported at the time of treatment.

3. The insurance carrier denied disputed services with claim adjustment reason codes:

   - 38 – services not provided or authorized by designated (network/primary care) providers.
   - Tr12 – pre-authorization was not obtained prior to the service/procedure being rendered.

   28 Texas Administrative Code §134.600(c)(1) states that the insurance carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsections (p) or (q) only when the following situations occur:

   (A) an emergency, as defined in Chapter 133 of this title (relating to General Medical Provisions);
   (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care

   Rule §134.600(p)(2) states that non-emergency health care requiring preauthorization includes outpatient surgical services. While the services in dispute *are* listed in subsection (p), as stated above, an emergency was supported at the time of treatment; therefore, the division concludes preauthorization was *not* required—pursuant to Rule §134.600(c)(1)(A).

4. The respondent argues that:

   > when the Provider first contacted the Carrier regarding preauthorization, the procedure was already under way. As such, no preauthorization could have been given for a procedure which had already occurred. . . . The Carrier, not knowing the procedure had already been performed, processed the preauthorization request through utilization review. The request was denied as not meeting medical necessity. That determination has never been appealed.

   However, medical necessity is not in dispute with regard to the disputed *medical bills*; neither party presented any EOBs with denial reasons related to, or plain language notice of, medical necessity issues related to the charges.

   Rule §133.307(d)(2) requires that in response to the request for medical fee dispute resolution the respondent shall provide any missing information not provided by the requestor and known to the respondent.

   Rule §133.307(d)(2)(B) requires the respondent to provide copies of all EOBs not submitted by the requestor.

   Rule §133.307(d)(2)(D) directs respondents to provide copies of any relevant documents not already provided.

   And Rule §133.307(d)(1) requires respondents to submit response information within 14 days after receipt of a request—after which the division may base its decision on the information available at the time of review.

   The only evidence presented by the insurance carrier related to medical necessity was the prospective utilization review and denial of the surgeon's *request for preauthorization*. But the division notes that the prospective review and denial of a request for authorization (which was never appealed or pursued) is not the same process or notice required as in the case of a retrospective review and denial of a medical bill.

   Even so, a review of the respondent's adverse determination against the request for preauthorization finds that it was not properly issued in accordance with division rules and requirements.

   Rule §134.600(i)(1) requires that the carrier shall contact the requestor or injured employee within three working days of receipt of a request for preauthorization with the decision to approve or issue an adverse determination on a request. The submitted documentation does not support this requirement was met.

The respondent's position statement acknowledges receiving the preauthorization request on July 12th, 2016. The adverse determination is dated July 18th, 2016; this date is more than three business days after the date the insurance carrier received the request for preauthorization. Although the UR agent documented attempts to contact the provider with opportunities for peer-to-peer review, he did *not* document the provider had been notified of the final decision within 3 business days of receipt of the request, and no other such supporting information was presented to MFDR. The division notes that July 12th was a Tuesday, and the third business day following receipt would have been Friday, July 15th. No intervening holidays are noted during that period. Based on the information presented to MFDR, the carrier's notice of adverse decision is untimely and does not meet the requirements of Rule §134.600(i).

Nevertheless, the denial of the *request for preauthorization* is not at issue in this medical fee dispute. There are different administrative proceedings for such disputes. The surgeon did not pursue an appeal of the authorization denial. At that point, an appeal of the denial of preauthorization would have been moot, after the surgery had already been performed. And such was not necessary, as an emergency was supported.

Rather, it is the denial of payments that are at issue in this dispute—not the preauthorization request. Denying a request for preauthorization is *not* equivalent to denying payment on a medical bill. Those are two separate processes. The insurance carrier must follow division rules and required bill review procedures—including giving appropriate plain language notices on the explanations of benefits, before issuing adverse determinations. And those requirements are not supported here.

Rule §133.240(q) requires that, when denying *payment* due to an adverse determination:

> the insurance carrier shall comply with the requirements of §19.2009 of this title (relating to Notice of Determinations Made in Utilization Review). Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Issuing Adverse Determination), including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor

And the division's Reconsideration Rule, §133.250(k), similarly requires that in any instance where the carrier is questioning the medical necessity or appropriateness of the health care services:

> the insurance carrier shall comply with the requirements of §19.2010 of this title (relating to Requirements Prior to Adverse Determination) and §19.2011 of this title, including the requirement that prior to issuance of an adverse determination on the request for reconsideration the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor

Moreover, Rule §133.250(a) provides that:

> If the health care provider is requesting reconsideration of a bill denied based on an adverse determination, the request for reconsideration constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations) and may be submitted orally or in writing.

The appeal procedures under 28 Texas Administrative Code §19.2011 have specific retrospective review and notification requirements—including Rule §19.2011(a)(4), which requires that the appeal decision be made by a physician who *has not previously reviewed the case*.

The rules make it clear that the insurance carrier may not "hide the ball." Payment denial language such as "Payment for this claim/service may have been provided in a previous payment"; or "a payment or denial has already been recommended for this service"; or "DUPL – these services have already been considered for reimbursement" are not sufficient to challenge the *medical necessity* of the services.

And such language is certainly not acceptable to use on an *initial* explanation of benefits—when the carrier has not previously considered the charges. Especially if the carrier intends, by vague allusion, to reference a prior *prospective* review of preauthorization. No provider could reasonably be expected to construe such a notice as a medical necessity denial, nor from it be adequately apprised of their rights, obligations and time limits involved.

Not only is it unacceptable for the reason that, in order to properly deny payment on a medical bill for lack of medical necessity, the carrier must say so in plain language and meet all requirements of the rules—including Rule §133.240(q), and those in 28 Texas Administrative Code, Chapter 19, Subchapter U.

But also because a carrier may not deny payment on medical necessity grounds based on a *prospective* review. To do so, a carrier must *retrospectively* review the services that were actually performed with due consideration of the complete medical record. Only after a retrospective UR may the carrier make a determination regarding the medical necessity of the services billed.

Likewise, in order to deny a second time on medical necessity grounds, after reconsideration of an appeal, carriers must meet the review and notification requirements of the appeals process, in accordance with Subchapter U, and Rule §133.250. Failure of the insurance carrier to include specific denial codes on the EOB indicating intent to deny for medical necessity, or failure to give required notices, may result in the division concluding that the insurance carrier did not maintain the medical necessity dispute at MFDR with respect to the disputed charges.

Review of the documentation submitted by the parties in this dispute finds no information to support that the carrier ever denied the disputed charges for reasons relating to medical necessity. Neither was documentation provided to support that the bills (along with the complete, post-surgical medical record) had undergone a *retrospective* utilization review—nor had they been submitted upon appeal for review by a separate physician. Because the carrier did not do so, medical necessity is not at issue; the defense has not been properly raised, and the respondent may not do so now. The division concludes there are no outstanding issues of medical necessity. The disputed services may therefore be reviewed per applicable division rules and fee guidelines.

5. In addition to the denial reasons addressed above, the insurance carrier denied the disputed services with claim adjustment reason codes:

   - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT.
   - 247 – A PAYMENT OR DENIAL HAS ALREADY BEEN RECOMMENDED FOR THIS SERVICE.
   - DUPL – THESE SERVICES HAVE ALREADY BEEN CONSIDERED FOR REIMBURSEMENT.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

   None of the submitted information supported previous payment—or any payment.
   The division finds reason code B13 is not supported.

   Again, with regard to payments, none are supported, and no documentation was presented to support a previous payment denial prior to the initial EOB—when reason code 247 was issued.
   Thus, Reason code 247 is also not supported.

   No documentation was presented to support the health care provider was seeking duplicate payments or submitting duplicate billing for services that had been previously paid. The duplicate billing was a request by the provider for the insurance carrier to review its final action. Reason code DUPL is not supported.

   Nothing was presented to support that additional (or any) payments were made on appeal or reconsideration. Reason code W3 is not supported.

   Rules §133.240 (e) and (e)(1) require that when paying, reducing or denying payment on a medical bill, the insurance carrier shall send to the health care provider an explanation of benefits in accordance with the elements required by Rules §133.500 and §133.501.

   Rule §133.3(a) requires that:

   > any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as "insurance carrier improperly reduced the bill" or "health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section.

Rule §133.307(d)(2)(F) requires that:

> The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

The respondent is limited at Medical Fee Dispute Resolution to arguing those denial reasons the carrier has presented to the requestor prior to the request for MFDR. The division looks to those reasons enumerated on the explanations of benefits (by code under the appropriate ASC X12N 837 code set, as specified in the elements required by Rule §133.500) as evidence of specific issues raised. Failure to raise specific denial reasons during the medical bill review process or reconsideration may be grounds for the division to find a waiver of defenses at MFDR. Any newly raised denial reasons or defenses shall not be considered in this review.

6. This dispute regards payment of medical services with reimbursement subject to the division's *Medical Fee Guideline for Professional Services*, at 28 Texas Administrative Code §134.203, which requires that to determine the maximum allowable reimbursement (MAR), system participants shall apply Medicare payment policies with minimal modifications as set forth in the rule. Rule §134.203(c) specifies that:

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the division conversion factor.

   For surgery performed in a facility setting, the 2016 division conversion factor is $71.32.

7. Reimbursement is calculated as follows:

   - Procedure code 20690 represents a professional service with reimbursement determined per Rule §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the division conversion factor. For this procedure, the relative value (RVU) for work of 8.78 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 8.93804. The practice expense (PE) RVU of 6.61 multiplied by the PE GPCI of 1.009 is 6.66949. The malpractice RVU of 1.71 multiplied by the malpractice GPCI of 0.772 is 1.32012. This procedure is subject to multiple procedure payment adjustment. The highest paying procedure is paid at 100%.The sum of 16.92765 is multiplied by the division conversion factor of $71.32 for a MAR of $1,207.28.

   - Procedure code 20690 represents a professional service with reimbursement determined per Rule §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the division conversion factor. For this procedure, the relative value (RVU) for work of 8.78 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 8.93804. The practice expense (PE) RVU of 6.61 multiplied by the PE GPCI of 1.009 is 6.66949. The malpractice RVU of 1.71 multiplied by the malpractice GPCI of 0.772 is 1.32012. This procedure is subject to multiple procedure payment adjustment. Payment for each subsequent procedure after the first is reduced by 50%. The sum of 16.92765 is multiplied by the division conversion factor of $71.32 which is multiplied by 50% for a MAR of $603.64.

- Procedure code 20694 represents a professional service with reimbursement determined per Rule §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the division conversion factor. For this procedure, the relative value (RVU) for work of 4.28 multiplied by the geographic practice cost index (GPCI) for work of 1.018 is 4.35704. The practice expense (PE) RVU of 4.65 multiplied by the PE GPCI of 1.009 is 4.69185. The malpractice RVU of 0.79 multiplied by the malpractice GPCI of 0.772 is 0.60988. This procedure is subject to multiple procedure payment adjustment. Payment for each subsequent procedure after the first is reduced by 50%. The sum of 9.65877 is multiplied by the division conversion factor of $71.32 which is multiplied by 50% for a MAR of $344.43.
- Procedure code 76001 has status indicator C, denoting services for which payment amounts are established on an individual case basis upon review of documentation. Procedure code 76001 may not be reported with code 20694 on the same date—a modifier is allowed to distinguish separate services, and if used appropriately may support separate payment. Review of the submitted documentation finds that separate payment for the fluoroscopy is not supported. Additionally, CMS does not determine a price or relative value for this service. If reimbursement is justified, it is paid at a fair and reasonable rate. This code is not assigned a relative value or payment amount. Per Rule §134.203(f), payment is provided in accordance with Rule §134.1 regarding fair and reasonable reimbursement. The insurance carrier allowed $0.00. Review of submitted information finds insufficient documentation to support a different payment amount from that determined by the carrier. Payment for this service is not recommended.

8. The total allowable reimbursement for the services in dispute is $2,155.35. This amount less the amount previously paid by the insurance carrier of $0.00, leaves an amount due to the requestor of $2,155.35. This amount is recommended.

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 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 established that additional reimbursement is due. As a result, the amount ordered is $2,155.35.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $2,155.35, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	May 5, 2017
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 Rule §133.307, effective May 31, 2012, *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. **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.