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
SUSAN VAN DE WATER, MD

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-18-1682-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and in compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider filed a DWC-60 requesting Medical Fee Dispute Resolution for a date of service of July 12, 2017. The DWC-60 was filed by Genesis Medical Management Solutions. They claimed to have submitted the medical bill to the carrier at fax number (214)404-0429. In fact, most of their documentation reflects a fax to that particular fax number. However, that fax number does not belong to the carrier nor to the carrier's medical bill review vendor. We have no idea whose fax number it is. However, it is not the carriers. The carrier has never received the medical bill in question. In order for the provider to file a DWC-60 , certain things must occur first. The provider must submit an initial medical bill to the carrier. After waiting 50 days for the carrier to respond, the provider may file a request for reconsideration. Both of these things must occur before the provider is entitled to file an appeal with the Medical Review Division via a DWC-60."

Respondent's Supplemental Position Summary dated March 30, 2018: "The carrier never received the provider's medical bill until the DWC-60 was filed. Once the carrier received that bill, the carrier process it. We are attaching a copy of an EOB dated March 27, 2018 that recommended reimbursement of $800.00."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 12, 2017	CPT Code 99456-WP	$800.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §134.210, effective July 7, 2016, provides the medical fee guideline for division specific services.
3. 28 Texas Administrative Code §134.235, effective July 7, 2016, sets the reimbursement guidelines for return to work evaluations.
4. The submitted explanation of benefits, EOBs, does not list any codes.

Issues

Is the requestor due additional reimbursement?

Findings

According to the DWC-60, the requestor is seeking reimbursement of $800.00 for CPT code 99456-WP rendered on July 12, 2017.

The respondent originally argued that reimbursement is not due because, "They claimed to have submitted the medical bill to the carrier at fax number (214)404-0429. In fact, most of their documentation reflects a fax to that particular fax number. However, that fax number does not belong to the carrier nor to the carrier's medical bill review vendor. We have no idea whose fax number it is. However, it is not the carriers. The carrier has never received the medical bill in question." The respondent wrote in the supplemental position summary that, "The carrier never received the provider's medical bill until the DWC-60 was filed. Once the carrier received that bill, the carrier process it. We are attaching a copy of an EOB dated March 27, 2018 that recommended reimbursement of $800.00."

A review of the submitted documentation finds the requestor was paid the disputed amount of $800.00; therefore, additional reimbursement is not due.

Conclusion

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

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		4/4/2018
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, 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 MDR 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.