



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Trenton D. Weeks, D.C.

Respondent Name

Valley Forge Insurance Company

MFDR Tracking Number

M4-19-3011-01

Carrier's Austin Representative

Box Number 57

MFDR Date Received

February 27, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After careful review of documentation it is concluded that this billed examination was properly performed, document, and submitted. Box 32 and 33 of the HICF1500 clearly shows service facility and provider information ... There has been no response from the carrier concerning Reconsideration sent 09/26/2018."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier specifically denied that the Claimant sustained a compensable injury in the course and scope of employment with our insured."

Response Submitted by: Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 6, 2018	Examination to Determine Maximum Medical Improvement (99456-NM)	\$350.00	\$350.00

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 §133.240 sets out the procedures for payment or denial of a medical bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examination to determine maximum medical improvement.
4. The submitted documentation did not include an explanation of benefits for the billed services in question.

Issues

1. Did the insurance carrier take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
2. Did the insurance carrier raise a new defense in its response?
3. Is Dr. Weeks entitled to reimbursement for the disputed service?

Findings

1. Dr. Weeks is seeking reimbursement for an examination to determine maximum medical improvement performed on February 6, 2018. Through evidence presented to the division, Dr. Weeks contends that the bill in question was returned as incomplete on May 14, 2018 and resubmitted to the insurance carrier on September 26, 2018.

The insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information.¹

The greater weight of evidence presented to the division supports that a complete bill for the services in question was received by the insurance carrier or its agent.

Brian J. Judis argued on behalf of the insurance carrier that the service in question was denied on an explanation of review based on entitlement to benefits. This explanation of review was not submitted to the division by the requestor or the insurance carrier. No evidence was provided to support that Valley Forge Insurance Company took final action on the bill for the service in question.

2. In its position statement, Brian J. Judis, on behalf of the insurance carrier, argued that the service in question was denied based on entitlement to benefits.

The response from the insurance carrier is required to address only the denial reasons presented to the requestor the request for medical fee dispute resolution (MFDR) was filed with the division. Any new denial reasons or defenses raised shall not be considered in this review.²

Because the insurance carrier failed to support that this denial reason was presented to Dr. Weeks prior to the request for MFDR, the division will not consider this argument in the current dispute review.

The dispute in question is not subject to dismissal as this denial reason was not sufficiently supported.

3. Because the insurance carrier failed to support that it took final action on the bill in question, Dr. Weeks is eligible for reimbursement of the disputed service.

The examining doctor is required to bill an examination to determine maximum medical improvement with CPT code 99456.³ Modifier "NM" is required when the examining doctor finds that the injured employee has not reached maximum medical improvement.⁴ Reimbursement is \$350.00 for this examination.⁵

The submitted documentation supports that Dr. Weeks performed an evaluation of maximum medical improvement and found that the injured employee was not at maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is \$350.00. 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 \$350.00.

¹ 28 Texas Administrative Code §133.240(a)

² 28 Texas Administrative Code §133.307(d)(2)(F)

³ 28 Texas Administrative Codes §§134.250(3)(C)

⁴ 28 Texas Administrative Code §134.250(2)(A)

⁵ 28 Texas Administrative Code §134.250(3)(C)

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 \$350.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____ Laurie Garnes _____	_____ March 7, 2019 _____
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.