



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

Karrn Bales, D.O.

Respondent Name

ACIG Insurance Company

MFDR Tracking Number

M4-19-3417-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

March 12, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted billing and additional documentation ... on 06/25/2018 via fax to James Hernandez, the adjuster named on the DWC 032 sent by TDI ... Our party contacted Tristar on 12/17/18 requesting an update on the bill's status; the insurance company claimed they had no record of the bill from the services rendered on 6/19/18. On 12/17/18, JKB Medical Exams faxed another copy of the DD report, DWC069, DWC073, and CMS1500 to the adjuster at fax number 562-506-0360."

Amount in Dispute: \$1,150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ACIG has no record of a bill on file for the disputed date of service."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 19, 2018	Designated Doctor Report	\$1,150.00	\$1,150.00

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 §133.20 sets out the procedures for submitting a medical bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine the ability of the injured employee to return to work.
4. 28 Texas Administrative Code §133.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

5. The documentation submitted does not include explanations of benefits.

Issues

- 1. Is the insurance carrier’s reason for denial of payment supported?
- 2. Dr. Bales entitled to reimbursement for the examination in question?

Findings

- 1. Dr. Bales is seeking reimbursement for an examination to determine the injured employee’s maximum medical improvement date and permanent impairment performed on June 19, 2018. In its position statement, Burns Anderson Jury & Brenner, L.L.P., on behalf of ACIG Insurance Company, stated that it did not receive a medical bill for the examination in dispute.

The health care provider is required to submit a medical bill within 95 days from the date of service.¹ Submitted evidence supports that the medical bill for the examination in question was submitted to Tristar, an agent of ACIG Insurance Company, by fax on June 25, 2018. This date is less than 95 days from the date of service.

The DWC concludes that ACIG Insurance Company’s argument based on timely filing is not supported.

- 2. The submitted documentation supports that Dr. Bales performed an evaluation of maximum medical improvement as ordered by the DWC. Therefore, the maximum allowable reimbursement (MAR) for this examination is \$350.00.²

The submitted documentation supports that Dr. Bales provided an impairment rating for the right ankle, a musculoskeletal body area, performing a full physical evaluation with range of motion. The MAR for this examination is \$300.00.³

The submitted documentation indicates that Dr. Bales performed an examination to determine the ability of the injured employee to return to work. The correct MAR for this examination is \$500.00.⁴

The total MAR for the disputed examination is \$1,150.00. 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 \$1,150.00.

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 \$1,150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	May 13, 2019 Date
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¹ 28 Texas Administrative Code §133.20(b)
² 28 Texas Administrative Code §134.250(3)(C)
³ 28 Texas Administrative Codes §§134.250(4)(C)(ii)(II)(-a-)
⁴ 28 Texas Administrative Code §134.235

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.