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
Varsha Gillala, D.O.

Respondent Name
Great Midwest Insurance Company

MFDR Tracking Number
M4-19-3526-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 22, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 30, 2018	Designated Doctor Examination	$500.00	$500.00

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 §134.240 sets out the billing requirements for designated doctors.
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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 275 – The charge was disallowed; as the submitted report does not substantiate the service being billed.
   - B12 – Services not documented in patients' medical records.
   - 1123 – We are unable to process the provider's re-billing, as the documentation does not specify the concern regarding the original analysis. Please re-submit with a clarification for the basis of the reconsideration.

- 16 – Claim/service lacks information which is needed for adjudication.
- W3 – Additional payment made on appeal/reconsideration.

Issues

1. Did Great Midwest Insurance Company respond to the medical fee dispute?
2. Is Dr. Gillala entitled to reimbursement for the examination in question?

Findings

1. The Austin carrier representative for Great Midwest Insurance Company is Flahive Ogden & Latson. Flahive Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on April 1, 2019. Rule §133.307(d)(1) states that if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. Dr. Gallala is seeking reimbursement for an examination to determine the injured employee's ability to return to work. Per explanation of benefits dated January 21, 2019, the insurance carrier denied the disputed examination stating that the service was not substantiated or documented in the medical records.

   Review of the documentation submitted by the health care provider finds a Form DWC073 and findings recorded in the narrative for the examination. The DWC concludes that available information supports that Dr. Gillala performed the examination in question.

   A doctor requested by the DWC or insurance carrier is required to bill an examination to determine the ability of the injured employee to return to work with CPT code 99456 and modifier "RE." [1] A designated doctor is required to include modifier "W8" to bills for an examination to determine the ability of the injured employee to return to work. Submitted CMS 1500 supports that Dr. Gallala billed the examination with CPT code 99456 and modifiers "W8" and "RE."

   Maximum allowable reimbursement for this examination is $500.00 and includes DWC-required reports.[2] 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 $500.00.

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 $500.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	August 2, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §134.235
[2] 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.