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
Benjamin Burris, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-19-3621-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 28, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE ATTACHED DOCUMENTATION STATES THAT OUR FACILITY DID NOT SUBMIT AN EOB REQUEST AN EOB. SOMEONE FROM OUR OFFICE CALLED ON 1/31/2019 TO CHECK THE STATUS OF THIS BILL AND GET INFORMATION ON PAYMENT OR AN EOB. AT THAT INFORMATION ON PAYMENT OR AN EOB. AT THAT TIME THEY WERE INFORMED THAT THE CARRIER DID NOT RECEIVE A COPY OF THE REPORT (THE ATTACHED VERSION HAS A TIME STAMP AS PROOF OF SUBMISSION TO THE CARRIER IN A TIMELY MANNER). THE CARRIER IS IN VIOLATION OF DWC RULE 133.240 AS OUR OFFICE DOES NOT HAVE PROOF OF SUBMISSION AND THE CARRIER FAILED TO TAKE FINAL ACTION ON THIS CLAIM."

Amount in Dispute: $1,200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "First, Texas Mutual has no record in the electronic claim file of receiving. Second, the requestor provided no fax confirmation that Texas Mutual received the fax … The bill is untimely. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 3, 2018	Examination to Determine Maximum Medical Improvement and Impairment Rating	$650.00	$650.00
November 3, 2018	Examination to Determine the Extent of the Compensable Injury	$500.00	$0.00
November 3, 2018	Calculation of Multiple Impairments	$50.00	$0.00
	Total	$1,200.00	$650.00

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. Burris entitled to reimbursement for the examination in question?

Findings

1. Dr. Burris is seeking reimbursement for an examination performed on November 3, 2018. In its position statement, Texas Mutual 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 Texas Mutual Insurance Company by fax on November 30, 2018. This date is less than 95 days from the date of service.

   The DWC concludes that Texas Mutual Insurance Company's argument based on timely filing is not supported.

2. The submitted documentation supports that Dr. Burris performed an evaluation of maximum medical improvement. The maximum allowable reimbursement (MAR) for this examination is $350.00.[2]

   The submitted documentation supports that Dr. Burris provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the spine. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[3]

   The services in question include an examination to determine the extent of the compensable injury billed using CPT code 99456 with modifier "RE." An examination to determine the extent of the compensable injury is billed using CPT code 99456 with modifier "RE" when the examination was requested by the DWC or the insurance carrier.[4] No evidence was received to support that the examination in question was requested by the DWC or the insurance carrier. No reimbursement is recommended for this service.

   When multiple impairment ratings are required as a component of a designated doctor examination, the additional impairment ratings are billed using CPT code 99456 with modifier "MI." No evidence was received to support that the examination in question was a designated doctor examination. No reimbursement is recommended for this service.

   The total MAR for the disputed services is $650.00. This amount is recommended.

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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

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 $650.00.

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 $650.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	May 28, 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.