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
Integrated Health Services

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-19-5169-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 12, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original report had a typo on the MMI/IR report in the middle of page 7 of 9 … We have sent this corrected report to the insurance carrier but they refuse to change their decision."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On the initial bill submitted, the provider noted the patient was at MMI on 1/10/18 with a 1% rating on the DWC 69 form, the exam submitted noted MMI was reached on 9/10/18 with 1% rating, and another rating of 2% towards the end of the exam … Further, Texas Mutual has no evidence the requestor, a non-network provider, received out of network approval to provide the service or treatment."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 2, 2019	Examination to Determine Maximum Medical Improvement and Impairment Rating	$650.00	$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 (DWC).

Background

1. 28 Texas Administrative Code §133.240 sets out the procedures for payment and denial of medical bills.
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 examinations to determine maximum medical improvement and impairment rating.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.

- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code description/instructions.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- DC4 – No additional reimbursement allowed after reconsideration.

Issues

1. Is this dispute subject to dismissal based on network status?
2. Are the insurance carrier's denials based on documentation supported?
3. Is Integrated Health Services entitled to reimbursement for the examination in question?

Findings

1. Integrated Health Services is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating on request of the injured employee's treating doctor.

   In its position statement, Texas Mutual Insurance Company stated that the injured employee's claim is part of the WorkWell Network. The insurance carrier asserted that Integrated Health Services is not part of the network and did not receive out-of-network approval for the examination in question.

   The DWC reviewed submitted documents and found no evidence that the insurance carrier presented a network denial to the requestor prior to the date the request for medical fee dispute resolution was filed.[1] Explanations of benefits provided to the DWC did not include a workers' compensation healthcare network name.[2]

   The DWC finds that the evidence presented is not sufficient to support a dismissal of the disputed examination based on network status.

2. The insurance carrier also argued that the examination was denied based on conflicting information in the report submitted to support the medical bill. Evidence supports that Integrated Health Services requested reconsiderations with corrections to the documentations, while the billing contained no changes.

   The explanations of benefits presented to the DWC indicate that the insurance carrier maintained its denial. Texas Mutual Insurance Company did not present any additional evidence to support its continued denial of the examination in question.

   The DWC concludes that this denial is not supported.

3. Because the insurance carrier failed to support a denial of the disputed examination, Integrated Health Services is entitled to reimbursement.

   The submitted documentation supports that Dr. Fred Romero performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.[3]

   The submitted documentation supports that Dr. Romero provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the left ring finger. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[4]

   The total allowed amount for this examination is $650.00. This amount is recommended.

[1] 28 TAC §133.307(d)(2)(F)
[2] 28 TAC §133.240(f)(15)
[3] 28 TAC §134.250(3)(C)
[4] 28 TAC §134.250(4)(C)(ii)(II)(-a-)

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the DWC 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 DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC 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	September 27, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.