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
PACIFIC BILLING

Respondent Name
EL PASO ISD

MFDR Tracking Number
M4-20-0321-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
October 2, 2019

Response Submitted By
No response received

REQUESTOR'S POSITION SUMMARY

"AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

RESPONDENT'S POSITION SUMMARY

The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF DISPUTE

Dates of Service	Disputed Services	Dispute Amount	Amount Due
April 9, 2019	Designated Doctor Examination	$350.00	$350.00

AUTHORITY

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC) in Title 28, Part 2 of the Texas Administrative Code.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out requirements for medical bill processing by insurance carriers.
3. 28 Texas Administrative Code §134.210 sets out guidelines for Texas workers' compensation specific services.
4. 28 Texas Administrative Code §134.240 sets out fee guidelines for designated doctor examinations.
5. 28 Texas Administrative Code §134.250 sets out fee guidelines for maximum medical improvement evaluations.
6. The insurance carrier did not take final action on the medical bill or the provider's request for reconsideration; the carrier further did not send any explanations of benefits to the health care provider and to date has not responded to the request for MFDR or provided any documentation to the division for consideration in this review. This decision is therefore based on the information available at the time of review.

Issues

1. Did the insurance carrier respond to the request for medical fee dispute resolution (MFDR)?
2. Did the insurance carrier take final action on the bill for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The Austin carrier representative for El Paso ISD is Downs Stanford, P.C., who acknowledged receipt of a copy of the MFDR request on October 9, 2019.

   28 Texas Administrative Code §133.307(d)(1) provides, if DWC does not receive a response within 14 calendar days of dispute notification, the dispute may be decided on the basis of the available information. To date, no response has been received. Consequently, this decision is based on the information available at the time of review.

2. The requestor presented documentation to support timely submission of the medical bill to the insurance carrier on April 18, 2019 but did not receive payment, any explanations of benefits or a response of any kind from the carrier.

   On June 14, 2019, the provider submitted the bill once more to the carrier, marked "request for reconsideration," including a request for an explanation of benefits. The provider did not receive a response to that request either and has now requested medical fee dispute resolution (MFDR) from DWC.

   28 TAC §133.240(a) requires an insurance carrier to take final action after conducting bill review on a complete medical bill (or determine to audit the bill), no later than 45 days after the date the insurance carrier receives the bill. No information was presented to support the carrier met this requirement.

   Although the insurance carrier's representative acknowledged receipt of the MFDR request, to date the carrier has not submitted a response for consideration in this review. Rule 28 TAC §133.307 (d) requires the carrier, upon receipt of the MFDR request, to send a response including a position statement, copies of explanations of benefits, and any relevant, missing information or records known to the respondent that have not already been provided by the requestor. The insurance carrier has failed to meet these requirements.

   Based on the evidence submitted for review, the carrier failed to pay or deny the initial bill and failed also to respond to the provider's request for reconsideration within the time limits allowed by DWC rules. The carrier has not presented any defenses to MFDR. The division will therefore review the disputed services for payment consistent with DWC rules and fee guidelines.

3. This dispute regards payment for a division ordered designated doctor examination for the evaluation of maximum medical improvement (MMI) and assignment of impairment rating (IR). Designated doctor examinations are Texas workers' compensation specific services. The fee guidelines are set out in Rules 28 TAC §134.240 and §134.250.

   Rule 28 TAC §134.240 (1)(B) requires that designated doctors performing MMI examinations shall bill and be reimbursed in accordance with Rule 28 TAC §134.250, using "W5" as the first modifier added to the billing code.

   Rule 28 TAC §134.250 (2)(A) requires an examining doctor, other than the treating doctor, who determines MMI has not been reached, shall bill and be reimbursed according to Rule 28 TAC §134.250 (3), using Modifier "NM."

   Because maximum improvement was not found, the employee's impairment was not evaluated.

   Rule 28 TAC §134.250 (3)(C) requires examining doctors (other than the treating doctor) to bill MMI evaluations using code 99456. Reimbursement is $350.00.

   The provider billed code 99456-W5-NM. The recommended amount is therefore $350.00 for the disputed services.

Conclusion

For the reasons above, the requestor established that payment is due. As a result, the amount ordered is $350.00.

ORDER

In accordance with Texas Labor Code Section 413.031 and 413.019 (if applicable), based on the submitted information, DWC finds the requestor is entitled to additional reimbursement. DWC hereby ORDERS the respondent to remit to the requestor $350.00, plus accrued interest per Rule §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	December 20, 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 28 TAC §133.307.

The appealing party must submit a *Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision* (form DWC045M). DWC must receive the request within twenty days of your receipt of this decision.

You may fax, mail or personally deliver the request to either the field office handling the claim or to DWC at the contact information on the form. You must send a copy to all other parties in the dispute at the same time you file the request. Include a **copy** of this **Medical Fee Dispute Decision** along with any other information required by 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.