



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

SCHNERINGER, JESSE OWEN

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-20-0426-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

October 17, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Medical records and billing were sent via fax on 04/11/2019 and 08/30/2019(with proof of timely filing) ..."

Amount in Dispute: \$1,150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "... the provider has failed to submit a request for reconsideration pursuant to Rule §133.250"

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 9, 2019	Designated Doctor Examination	\$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 (DWC).

Background

- 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill.
- 28 Texas Administrative Code §133.250 sets out the procedures for submitting a request for reconsideration of a medical bill.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine ability to return to work.
- 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 29 – The time limit for filing has expired.
 - 4271 – Per TX Labor Code Sec. 413.016, providers must submit bills to payors within 95 days of the date of service.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Did Dr. Schneringer submit a request for reconsideration to the insurance carrier for the medical bill in question?
3. Is Dr. Schneringer entitled to reimbursement for the examination in question?

Findings

1. Dr. Schneringer is seeking reimbursement for a designated doctor examination performed on April 9, 2019. Dr. Schneringer asserted that "Medical records and billing were sent via fax on 04/11/2019 and 08/30/2019."

The health care provider is required to submit a medical bill to the insurance carrier not later than the 95 days after the date of service, with few exceptions.¹

An explanation of benefits dated September 10, 2019, presents the insurance carrier's denial of payment based on timely filing of the medical bill. Dr. Schneringer submitted evidence to the DWC to support that a complete medical bill was submitted to the insurance carrier via fax on April 11, 2019. This date is less than 95 days from the date of service.

The DWC finds that the greater weight of evidence finds that Dr. Schneringer submitted a complete medical bill for the services in question less than 95 days from the date of service. The insurance carrier's denial of payment is not supported.

2. No evidence was provided indicating that State Office of Risk Management took final action on the medical bill submitted via fax on April 11, 2019. A health care provider may submit a request for reconsideration if it has not received an explanation of benefits within 50 days from submitting the medical bill to the insurance carrier.²

In its position statement, the insurance carrier asserted that Dr. Schneringer "failed to submit a request for reconsideration."

Per explanation of benefits dated September 10, 2019, State Office of Risk Management indicated that a bill for the services in question was received on August 30, 2019, which is the date of the request for reconsideration asserted by Dr. Schneringer.

The DWC finds that the greater weight of evidence supports that Dr. Schneringer submitted a request for reconsideration to the insurance carrier.

3. The submitted documentation supports that Dr. Schneringer performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is \$350.00.³

The submitted documentation supports that Dr. Schneringer provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the right knee. Reimbursement is \$300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.⁴

¹ 28 TAC §133.20(b)

² 28 TAC §133.250(c)(2)

³ 28 TAC §134.250(3)(C)

⁴ 28 TAC §134.250(4)(C)(ii)(II)(-a-)

The submitted documentation indicates that Dr. Schneringer performed an examination to determine the injured employee's work status. The MAR for this examination is \$500.00.⁵

The total allowed amount for the disputed examination is \$1,150.00. This amount is recommended.

Conclusion

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 \$1,150.00.

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 \$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

	Laurie Garnes	November 14, 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.

⁵ 28 TAC §134.235