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
BURRIS, BENJAMIN S.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-20-0532-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 24, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "AS STATED ON THE PREVIOUS RFR THE REPORT WAS SUBMITTED ON 05/03/2019 WITHIN IN THE 95 DAY TIMELY FILING WINDOW. THE ORIGINAL REPORT HAS THE TIME STAMP AS PROOF."

Amount in Dispute: $1,100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual on 7/2/19 received a bill from **BENJAMIN BURRIS MD** … The fax cover sheet with that billing states 'Note: 2ND SUBMISSION, ORIGINAL CONFIRMATION FROM 5/3/2019 IS ATTACHED.' Texas Mutual reviewed the document, which are provided under the attachment, and found no 5/3/19 confirmation."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2019	Examination to Determine Maximum Medical Improvement and Impairment Rating	$1,100.00	$1,100.00

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. The insurance carrier denied payment for the disputed services based on timely filing.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. Is the requestor entitled to reimbursement for the examination in question?

Findings

1. Dr. Burris is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating. The insurance carrier denied payment for failure to timely file the bill.

   With few exceptions, the health care provider is required to submit its medical bill to the insurance carrier within 95 days from the date of service.[1]

   Dr. Burris presented evidence to the DWC to support that the medical bill in question was submitted on or about May 3, 2019. This is within the 95-day requirement. The Texas Mutual Insurance Company's denial of payment 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]

   Review of the submitted documentation finds that Dr. Burris performed impairment rating evaluations of the spine, head, liver, and left eye.

   The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[3] The MAR for the evaluation of non-musculoskeletal body areas is $150.00 each.[4]

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement			$350.00
IR: Spine (ROM)	Musculoskeletal System	Spine and Pelvis	$300.00
IR: Head	Nervous System	Body Systems	$150.00
IR: Liver	Digestive System	Body Systems	$150.00
IR: Left Eye	Visual System	Body Systems	$150.00
Total MMI			**$350.00**
Total IR			**$750.00**
Total Exam			**$1,100.00**

The total allowed amount for the disputed examination is $1,100.00. 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 $1,100.00.

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 $1,100.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

[1] 20 TAC §133.20(b)
[2] 28 TAC §134.250(3)(C)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[4] 28 TAC §134.250(4)(D)(v)

Authorized Signature

	Laurie Garnes	December 19, 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.