



# 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**

HERITAGE NETWORK PHYSICIAN SERVICES

**Respondent Name**

STARR INDEMNITY & LIABILITY CO

**MFDR Tracking Number**

M4-20-1056-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

December 27, 2019

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The original claim form was properly coded and submitted in a timely fashion to the carrier."

**Amount in Dispute:** \$1,400.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The bill was not received by ESIS, Inc. until 1-9-2020 and has been properly denied for timely filing. Furthermore, per the attached HCFA form the bill was not mailed to ESIS, Inc."

**Response Submitted by:** ESIS

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 2019	Designated Doctor Examination	\$1,400.00	\$1,400.00

#### 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 §133.20 sets out the procedures for submitting medical bills.
2. 28 Texas Administrative Code §133.210 sets out the procedures regarding documentation.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine extent of the compensable injury and ability to return to work.
5. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
6. Submitted documentation did not include evidence of explanations of benefits provided prior to this medical

fee dispute resolution request.

### **Issues**

1. Did Starr Indemnity & Liability Company take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
2. Is Heritage Network Physician Services entitled to reimbursement for the examination in question?

### **Findings**

1. Heritage Network Physician Services is seeking reimbursement for a designated doctor examination performed on August 29, 2019.

Heritage Network Physician Services argued that it had not received payment or an explanation of denial for medical bills submitted for the examination in question. ESIS, on behalf of Starr Indemnity & Liability Company, argued that “the bill was not received by ESIS, Inc. until 1-9-2020.”

The insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information.<sup>1</sup>

The greater weight of evidence presented to the DWC supports that a complete bill for the services in question was received by the insurance carrier or its agent on or about September 9, 2019, and October 22, 2019.

The insurance carrier has the burden to provide its agents with any documentation necessary for the resolution of a medical bill. The DWC considers any medical billing information possessed by one entity to be simultaneously possessed by the other.<sup>2</sup>

No evidence was provided to support that the insurance carrier took final action on the bill for the service in question.

2. Because the insurance carrier failed to provide any denial for the services in question prior to medical fee dispute resolution, the DWC finds that Heritage Network Physician Services is entitled to reimbursement.

The submitted documentation supports that Edward W. Smith, D.O. performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is \$350.00.<sup>3</sup>

The submitted documentation supports that Dr. Smith provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the upper extremity. Reimbursement is \$300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.<sup>4</sup>

The submitted documentation indicates that Dr. Smith performed an examination to determine the extent of the compensable injury and the ability to return to work. The MAR for such examinations is \$500.00.<sup>5</sup> Not including maximum medical improvement and impairment rating, when multiple examinations of this type are required, the first examination is reimbursed at 100%, the second examination is reimbursed at 50%, and additional examinations are reimbursed at 25%.<sup>6</sup> For this dispute, the MAR for the examination to determine extent of the compensable injury is \$500.00. The examination to determine the ability to return to work is \$250.00.

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<sup>1</sup> 28 TAC §133.240 (a)

<sup>2</sup> 28 TAC §133.210 (e)

<sup>3</sup> 28 TAC §134.250(3)(C)

<sup>4</sup> 28 TAC §134.250(4)(C)(ii)(II)(-a-)

<sup>5</sup> 28 TAC §134.235

<sup>6</sup> 28 TAC §134.240 (2)

The total allowance for the designated doctor examination in question is \$1,400.00. 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 \$1,400.00.

**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 \$1,400.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

May 14, 2020

**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.**