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
PACIFIC BILLING

Respondent Name
Great Divide Insurance Company

MFDR Tracking Number
M4-20-1100-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
December 31, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "No Response To Billing"

Amount in Dispute: $586.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 1, 2019	Designated Doctor Examination	$500.00	$500.00
August 1, 2019	Manual Muscle Testing (95831 x 2)	$86.30	$55.11
	Total	$586.30	$555.11

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 or denial of a medical bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional services.
4. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine extent of injury.
5. The submitted documentation did not include explanations of benefits.

Issues

1. Did Great Divide Insurance Company respond to the medical fee dispute?
2. Did Great Divide Insurance Company take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
3. Is Pacific Billing entitled to reimbursement for the examination in question?

Findings

1. The Austin insurance carrier representative for Great Divide Insurance Company is Burns Anderson Jury & Brenner LP. The representative received the copy of this medical fee dispute on January 8, 2020. If the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.[1]

   As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. Pacific Billing is seeking reimbursement for a designated doctor examination to determine the extent of the compensable injury.

   Pacific Billing argued that it had not received payment for medical bills submitted for the examination in question. Burns Anderson Jury & Brenner LP, on behalf of the insurance carrier, failed to present any argument for lack of payment.

   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.[2]

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

3. Because the insurance carrier failed to support non-payment of the disputed examination, Pacific Billing is entitled to reimbursement.

   The submitted documentation indicates that James Scott, M.D. performed an examination to determine the extent of the compensable injury. Reimbursement is $500.00 and includes DWC-required reports.[3]

   The submitted documentation supports that Dr. Scott performed muscle testing, as represented by procedure code 95831, for the spine. While Pacific Billing is requesting reimbursement for two units, only one unit was supported by the documentation received by the DWC. Health care providers that perform medical services in an office setting apply the Medicare payment policies with minimal modifications.[4]

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the division conversion factor. The division conversion factor for 2019 is $59.19. The MAR for CPT code 95831, one unit, is $55.11.

   The total amount payable for the examination in question is $555.11. 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 $555.11.

[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §133.240 (a)
[3] 28 TAC §134.235
[4] 28 Texas Administrative Code §133.203(c)

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 $555.11, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	February 25, 2020
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.