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
MED-LOSS INC

Respondent Name
XL Insurance America, Inc.

MFDR Tracking Number
M4-20-1648-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 4, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The charges were for 99456 W5-WP $500.00. We were paid $350.00. Which is not according to the Texas Fee Guidelines, and also 99456 SP $50.00 for additional testing report incorporation was not paid according to Texas Fee Guideline."

Amount in Dispute: $200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the attached amended EOR allowing and additional $150.00 for 03/08/2019 for the IR rating that was underpaid, as requested by the provide. 99456 SP $50.00 charge, was never received by the carrier and the provider has failed to show proof it was submitted with in 95 days."

Response Submitted by: Coventry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 18, 2019	Designated Doctor Examination – 99456-W5-WP	$150.00	$0.00
March 18, 2019	Designated Doctor Examination – 99456-SP	$50.00	$0.00
	Total	$200.00	$0.00

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 §133.20 sets out the procedures for submitting a medical bill.

Issues

1. Is Med-Loss, Inc. entitled to additional reimbursement for procedure code 99456-W5-WP?
2. Is Med-Loss, Inc. entitled to additional reimbursement for procedure code 99456-SP?

Findings

1. Med-Loss, Inc. is seeking, in part, $150.00 additional reimbursement for an examination to determine maximum medical improvement and impairment rating, represented by procedure code 99456-W5-WP. Per explanation of benefits submitted by Coventry, on behalf of XL Insurance America, Inc., the insurance carrier did not maintain its denial of this charge and reimbursed it in full. No additional reimbursement for this charge is recommended.

2. Med-Loss, Inc. is also seeking reimbursement of $50.00 for incorporating a report from a specialist, represented by procedure code 99456-SP, into the examination.

   Coventry argued that the insurance carrier did not receive this charge until the request for medical fee dispute. In its position statement, it provided copies of bills received by the insurance carrier.

   A health care provider is required to file a medical bill within 95 days from the date of service with few exceptions.[1] Med-Loss, Inc. stated that a corrected bill that included this charge had been submitted to the insurance carrier within 95 days from the date of service. No evidence was provided to support this argument.

   Because Med-Loss, Inc. failed to support its request for this charge, no reimbursement can be recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	March 27, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §133.20 (b)

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.