TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BURRIS, BENJAMIN S.

Respondent Name
BITCO NATIONAL INSURANCE CO

MFDR Tracking Number
M4-20-2125-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 4, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CARRIER STATES THAT THE NARRATIVE STATES THAT THIS IS A 'POST DDE' AND THE DWC 69 INDICATES THIS IS A REFERRAL EXAM FROM THE TREATING DOCTOR. PLEASE NOTE THE RULE GOVERNING PDD EXAMS."

Amount in Dispute: $1,890.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In this case, the examination by the designated doctor was not the first evaluation of MMI and IR. The Claimant had the first evaluation completed in 2018. Therefore, the evaluation should not have been completed per the statute, and Respondent should not be liable for payment of the examination."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 5, 2019	99456-WP; 99456-W6-RE; 99456-W7-RE; 99456-W8-RE; 99456-MI; 99080-73	$1,890.00	$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 §133.305 sets out the procedures for resolving medical disputes.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Insurance Code (TIC) Chapter 1305 applicable to Health Care Certified Networks.
4. 28 TAC §§10.120 through 10.122 address the submission of a complaint by a health care provider to the Health Care Network.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 234 – This procedure is not paid separately.
   - 242 – Services not provided by network/primary care prov
   - NNP – Out-of-network approval not requested prior to rendering services.
   - Notes: "Per rule 134.20(e) -This modifier shall be added to CPT code 99456 when the designated doctor is required to complete multiple impairment ratings calculations. This is not a DD exam."

Issues

Is this dispute eligible for medical fee dispute resolution (MFDR) through the DWC?

Findings

The requestor filed this medical fee dispute to the DWC asking for reimbursement of an examination to re-evaluate questions previously addressed by a designated doctor. The authority of the DWC to apply Texas Labor Code statutes and rules is limited to non-network health care.[1] An insurance carrier that contracts with a certified health care network shall reimburse out-of-network care if the health care was:

- an emergency,
- provided to an injured employee who lives outside of network coverage areas, or
- provided by an out-of-network health care provider with a referral from the injured employee's treating doctor that has been approved by the network.[2]

The requestor therefore has the burden to prove that one of these conditions was met to be eligible for dispute resolution through the DWC. No evidence was provided to support that any of the above conditions were met. For this reason, the services in dispute are not eligible for MFDR through the DWC.

The DWC notes that the requestor may use the complaint process for health care networks for the disputed services.[3] If the health care provider is dissatisfied with the outcome of the network complaint process, the health care provider may appeal through the TDI's Complaint Resolution Process.[4]

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

		June 8, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

[1] TIC §1305.003; 28 TAC §133.305 (a)(4)
[2] TIC §1305.006; TIC §1305.103
[3] TIC §§1305.401 - §1305.405
[4] 28 TAC §§10.120 through 10.122

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 division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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.