



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

Requester Name

HALABY, GERALD ALLAN

Respondent Name

UNITED WISCONSIN INSURANCE CO

MFDR Tracking Number

M4-20-2960-01

Carrier's Austin Representative

Box Number 06

MFDR Date Received

August 18, 2020

REQUESTER'S POSITION SUMMARY

"AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED. THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: \$1,700.00

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
February 21, 2020	Designated Doctor Examination (99456-W5-WP)	\$1,100.00	\$1,100.00
February 21, 2020	Designated Doctor Examination (99456-W5-MI)	\$100.00	\$100.00
February 21, 2020	Designated Doctor Examination (99456-W6-RE)	\$500.00	\$500.00
Total		\$1,700.00	\$1,700.00

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 §133.240 sets out the procedures for payment or denial of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine the extent of the compensable injury.
4. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 16 – Claim/service lacks information or has submission/billing error(s).
 - 205-1 – Disallowed, charges will be reviewed upon receipt of supporting info: such as reports, notes, or invoice. Resubmit with original bill.
 - M127 – Missing patient medical record for this service.
 - MA27 – Missing/incomplete/invalid entitlement number or name shown on claim.
 - MA30 – Missing/incomplete/invalid type of bill.
 - N179 – Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.

Issues

1. Did United Wisconsin Insurance Company respond to the medical fee dispute?
2. Is the insurance carrier's denial of payment based on missing, incomplete, or invalid billing supported?
3. Is the insurance carrier's denial of payment based on lack of documentation supported?
4. Is Gerald Halaby, M.D. entitled to reimbursement for the examination in question?

Findings

1. The Austin carrier representative for United Wisconsin Insurance Company is Stone, Loughlin & Swanson, LLP. The representative was notified of this medical fee dispute on August 25, 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. Dr. Halaby is seeking reimbursement for a designated doctor examination to determine maximum medical improvement (MMI), impairment rating (IR), and the extent of the compensable injury.

United Wisconsin Insurance Company denied the examination, in part, based on billing or submission errors and on missing, incomplete, or invalid billing. Review of the submitted CMS 1500 forms, the DWC finds that the insurance carrier did not support its denial of payment for this reason.

3. The insurance carrier also denied the disputed examinations for failing to submit the medical reports. The greater weight of evidence submitted to the DWC supports that a report was submitted with billing on or about June 2, 2020. The insurance carrier did not support its denial of payment for this reason.
4. Because the insurance carrier failed to support its denial the examinations in question, the DWC concludes that Dr. Halaby is entitled to reimbursement.

The submitted documentation supports that Dr. Halaby performed an evaluation of MMI as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is \$350.00.²

Review of the submitted documentation finds that Dr. Halaby performed IR evaluations of the upper extremities, lower extremities, spine, and head with range of motion testing. 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 subsequent musculoskeletal body areas is \$150.00 each.⁴ The MAR for the assignment of impairment rating for non-musculoskeletal body areas is \$150.00 each.⁵ The total MAR for the determination of impairment rating is \$750.00.

¹ 28 TAC §133.307(d)(1)

² 28 TAC §134.250(3)(C)

³ 28 TAC §134.250(4)(C)(ii)(II)(-a-)

⁴ 28 TAC §134.250(4)(C)(ii)(II)(-b-)

⁵ 28 TAC §134.250(4)(D)(v)

The submitted documentation indicates that Dr. Halaby was ordered to address MMI, IR, and extent of injury. The narrative report and enclosed forms support that these evaluations were performed, and two additional impairment ratings were provided. Therefore, the correct MAR for this service is \$100.00.⁶

The submitted documentation indicates that Dr. Halaby performed an examination to determine the extent of the compensable injury. The correct MAR for this examination is \$500.00.

The total allowable reimbursement is \$1,700.00. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requester has established that additional reimbursement is due. As a result, the amount ordered is \$1,700.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requester is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requester \$1,700.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____	November 5, 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.

⁶ 28 TAC §134.250(4)(B)