Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
John J. Debender, MD

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-11-2256-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 7, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…THIS PATIENT WAS SCHEDULED AND SEEN BY OUR OFFICE THRU THE TEXAS DEPARTMENT OF INSURANCE.

WE RECEIVED A DENIAL FOR PAYMENT STATING THAT DUE TO RULE 180.021 (M) (9), WE WERE NOT ENTITLED TO PAYMENT, BECAUSE WE AE HCN NETWORK PROVIDER FOR THE TEXAS STAR PROGRAM.

WE WERE NOT AWARE THAT THIS PT WAS IN THE NETWORK, AS YOU CAN SEE ON FORM #32, BOX 22 CLEARLY SHOWS THAT NA WAS INSERTED IN THAT AREA.

WE ARE MAKING A REQUEST FOR REIMBURSEMENT FOR THE TDI REQUESTED EXAMINATION."

Amount in Dispute: $1150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor complains Texas Mutual denied payment for designated doctor services performed 11/11/10.

The requestor is a participating doctor in the Texas Star Network…

Texas Mutual claim … is in the same Network…

DWC Rule 126.7 states in part, '…A doctor who has contracted with or is employed by an authorized workers' compensation health care network established under Chapter 1305, Insurance Code, (network doctor) may not perform a designated doctor examination, as those terms are used under Texas Workers' Compensation Act, for an employee receiving medical care through the same network.'

DWC has not provided any waivers or exceptions to this proscription.

Therefore, no payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 11, 2010	Designated Doctor Examination (MMI/IR/RTW)	$1150.00	$650.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §126.7 provides guidance regarding requests for designated doctor requests and examinations for date of service November 11, 2010 (31 Tex Reg 6351).
3. 28 Texas Administrative Code §134.1 addresses medical reimbursement for this date of service.
4. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursement of designated doctor examinations, including this date of service.
5. 28 Texas Administrative Code §180.21 provides guidance regarding the Division Designated Doctor List for this date of service.
6. Texas Labor Code §408.0041, effective September 1, 2007, provides guidance for designated doctor examinations.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-B5 – Coverage/program guidelines were not met or were exceeded.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
   - 198 – Allowance was reduced as per contractual agreement.
   - 724 – No additional payment after a reconsideration of services.
   - 728 – This bill was reviewed/denied in accordance with your First Health contract.

Issues

1. Is the insurance carrier's reason for denial of payment of the disputed services supported?
2. What is the correct MAR for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The dispute involves reimbursement of fees for a designated doctor examination. The insurance carrier denied payment because the designated doctor was contracted with the same network under which the injured employee's claim is administered, using claim adjustment codes 198 – "ALLOWANCE WAS REDUCED AS PER CONTRACTUAL AGREEMENT," and 728 – "THIS BILL WAS REVIEWED/DENIED IN ACCORDANC WITH YOUR FIRST HEALTH CONTRACT."

   28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 364, states, "(b) Medical reimbursement for health care services provided to injured employees subject to a workers' compensation health care network established under Insurance Code Chapter 1305 shall be made in accordance with the provisions of Insurance Code Chapter 1305, **except as provided in subsections (c)** [emphasis added] and (d) of this section. (c) Examinations conducted pursuant to Labor Code §§408.004, **408.0041** [emphasis added], and 408.151 **shall be reimbursed in accordance with §134.204** [emphasis added] of this chapter…"

   Texas Labor Code §408.0041, effective September 1, 2007, provides the authority of the Commissioner of the Division of Workers' Compensation to order a designated doctor examination. Further, subsection (h) of this statute states, "The insurance carrier shall pay for: (1) an examination required under Subsection (a)."

   Review of the submitted documentation finds that the requestor was ordered to perform the designated doctor examination in question via EES-14 dated October 25, 2010. Therefore, the disputed services were provided pursuant to Texas Labor Code §408.0041 (a). The insurance carrier's reason for denial is not supported and shall be reviewed according to 28 Texas Administrative Code §134.204.

2. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is $350.00.

   Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (C)(ii) The MAR for musculoskeletal body areas shall be as follows. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." The submitted documentation indicates that the Designated Doctor performed a full physical evaluation with range of motion

for the right wrist to find the Impairment Rating. Therefore, the correct MAR for this examination is $300.00.

28 Texas Administrative Code §134.204 (i) (1) states, "Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: (E) Ability of the employee to return to work shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier 'W8'." Further, 28 Texas Administrative Code §134.204 (k) states, "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, **the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.'** In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee." The submitted documentation indicates that the Designated Doctor performed an examination to determine Return to Work. The CMS-1500 provided indicates that the examination was billed using modifiers W8/WP, which is not appropriate according to the referenced rules. Therefore, the correct MAR for this examination is $0.00.

3. The total allowable for the disputed services is $650.00. The insurance carrier paid $0.00. Therefore, the Division finds that the requestor is entitled to a reimbursement of $650.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $650.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	December 8, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.