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
Durga Sunkara, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-11-4251

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 21, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT FOR SERVICES…"

Amount in Dispute: $850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… The requestor is a participating doctor in the Texas Star Network… Texas Mutual claim … is in the same Network…

DWC Rule 180.21(a)(2)(F) states in part, 'Any association that may reasonably be perceived as having potential to influence the conduct or decision of a doctor, which may include… a contract with the same workers' compensation health care network that is responsible for the provision of medical benefits to the injured employee…'

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
April 27, 2011	Designated Doctor Examination	$850.00	$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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §130.6, effective January 1, 2007, 33 TexReg 6368, sets out the procedures for Designated Doctor examinations for maximum medical improvement and impairment ratings.

3. 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 TexReg 364, addresses medical reimbursement for this date of service.
4. 28 Texas Administrative Code §134.204, effective March 1, 2008, 33 TexReg 364, sets out the fee guidelines for billing and reimbursement of division-specific services.
5. Texas Labor Code §408.0041, effective September 1, 2007, provides guidance for designated doctor examinations.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-W1 – Workers compensation state fee schedule adjustment
   - 788 – Texas Star Network Dr. may not perform DD exams for workers receiving care through same network per Chapter 126 &/or 127 and Rule 180.21.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional 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 code 788 – "TEXAS STAR NETWORK DR. MAY NOT PERFORM DD EXAMS FOR WORKERS RECEIVING CARE THROUGH SAME NETWORK PER CHAPTER 126 &/OR 127 AND RULE 180.21."

   28 Texas Administrative Code §134.1 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 April 8, 2011. Therefore, the disputed services were provided pursuant to Texas Labor Code §408.0041(a). The insurance carrier's reason for denial of payment 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 supports 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.

   28 Texas Administrative Code §134.204(j)(4) states that:

   (D) …
   (i) Non-musculoskeletal body areas are defined as follows:
   (I) body systems;
   (II) body structures (including skin); and,
   (III) mental and behavioral disorders.

(ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides…
(v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

Review of the submitted documentation finds that the requestor performed an impairment rating evaluation of a facial laceration and a head contusion. Therefore, the correct MAR for this examination is $300.00.

Furthermore, 28 Texas Administrative Code §134.204(j)(4)(B) states,

> When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title …, the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier 'MI' shall be added to the MMI evaluation CPT code.

28 Texas Administrative Code §130.6(b)(5) states,

> When the extent of the injury may not be agreed upon by the parties (based upon documentation provided by the treating doctor and/or insurance carrier or the comments of the employee regarding his/her injury), the designated doctor shall provide multiple certifications of MMI and impairment ratings that take into account the various interpretations of the extent of the injury so that when the Division resolves the dispute, there is already an applicable certification of MMI and impairment rating from which to pay benefits as required by the Act.

The submitted documentation supports that 1 additional impairment ratings were provided. Therefore, the correct MAR for this service is $50.00.

3. The total MAR for the disputed services is $700.00. The insurance carrier paid $0.00. A reimbursement of $700.00 is recommended.

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 $700.00.

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 $700.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	January 22, 2016
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 MFDR 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 this *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.