



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

Trenton D. Weeks, DC

Respondent Name

Indemnity Insurance Company of North America

MFDR Tracking Number

M4-13-1126-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

January 7, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This examination was performed for the purpose of determining MMI and Impairment as it related to the work injury... This report and bill was performed according to TDWC rules and should be paid in full."

Amount in Dispute: \$800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has disputed that reimbursement is owed for these services as they were not reasonable and necessary. Claimant had previously been evaluated on these issues by a designated doctor."

Response Submitted by: Flahive, Ogden & Latson, Post Office Drawer 201329, Austin, TX 78720

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: January 19, 2012, Referral Doctor Examination to determine Maximum Medical Improvement and Impairment Rating, \$800.00, \$800.00

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 §133.240 sets out the procedures for payment or denial of medical bills.
3. 28 Texas Administrative Code §134.204 provides the fee guidelines for division-specific services.
4. 28 Texas Administrative Code §134.600 defines services subject to pre-authorization requirements.
5. 28 Texas Administrative Code §19.2003 provides definitions for terms related to utilization reviews.

6. 28 Texas Administrative Code §19.2009 sets out the procedures for notices of determination of utilization reviews.
7. 28 Texas Administrative Code §19.2010 provides the requirements prior to issuing adverse determinations of utilization review.
8. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 96 – Non-covered charge(s).
 - 850-665 – Non Covered Services
 - 197 – Precertification/authorization/notification absent.
 - 881-015 – Payment denied/reduced for absence of precertification/authorization.
 - W1/850-664 – No additional reimbursement allowed after review of appeal/reconsideration.
 - Note: This service was not considered reasonable or necessary for the medical causality problem.

Issues

1. Did the insurance carrier appropriately raise medical necessity for this dispute?
2. Is the service in dispute a covered service?
3. Are the requested services subject to pre-authorization requirements defined in 28 Texas Administrative Code §134.600?
4. What is the maximum allowable reimbursement for the disputed services?
5. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services stating, “THIS SERVICE WAS NOT CONSIDERED REASONABLE OR NECESSARY FOR THE MEDICAL CAUSALITY PROBLEM.”

Retrospective utilization review is defined in 28 Texas Administrative Code §19.2003(b)(31) as,

A form of utilization review for health care services that have been provided to an injured employee. Retrospective utilization review does not include review of services for which prospective or concurrent utilization reviews were previously conducted or should have been previously conducted.

In addition, 28 Texas Administrative Code §133.240(q) states, in relevant part,

When denying payment due to an adverse determination under this section, the insurance carrier shall comply with the requirements of §19.2009 of this title ... Additionally, in any instance where the insurance carrier is questioning the medical necessity or appropriateness of the health care services, the insurance carrier shall comply with the requirements of §19.2010 of this title ..., including the requirement that prior to issuance of an adverse determination the insurance carrier shall afford the health care provider a reasonable opportunity to discuss the billed health care with a doctor ...

Submitted documentation does not support that the insurance carrier followed the appropriate procedures for a retrospective review denial of the disputed services outlined in §19.2003(b)(31) or §133.240(q). Therefore, the insurance carrier did not appropriately raise medical necessity for this dispute.

2. The insurance carrier denied disputed services with claim adjustment reason codes 96 – “Non-covered charge(s),” and 850-665 – “NON COVERED SERVICES.” Review of the submitted documentation finds that the requested services are division-specific services as defined by 28 Texas Administrative Code §130.1 and §134.204. Therefore, the service in dispute is a covered service for workers’ compensation. The insurance carrier’s denial for this reason is not supported.
3. The insurance carrier denied services with claim adjustment reason codes 197 – “Precertification/authorization/notification absent,” and 881-015 – “PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.” Review of the submitted documentation finds that the requested service is not included in the list of services subject to the pre-authorization requirements found in 28 Texas Administrative Code §134.600. The insurance carrier’s denial for this reason is not supported.
4. 28 Texas Administrative Code §134.204 (j)(3) states, “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 requestor performed an evaluation of Maximum Medical Improvement. 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) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

- (i) Musculoskeletal body areas are defined as follows:
 - (I) spine and pelvis;
 - (II) upper extremities and hands; and,
 - (III) lower extremities (including feet).
- (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; and
 - (-b-) \$150 for each additional musculoskeletal body area.

The submitted documentation indicates that the requestor provided an impairment rating and performed a full physical evaluation with range of motion for the spine and left upper extremity. Therefore, the correct MAR for this examination is \$450.00.

5. The total MAR for the disputed service is \$800.00. The insurance carrier paid \$0.00. A reimbursement of \$800.00 is recommended.

Conclusion

While all evidence may not have been discussed, it was considered. 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 \$800.00.

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 \$800.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

<p>_____</p>	<p>Laurie Garnes</p>	<p>January 15, 2016</p>
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 28 Texas Administrative Code §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 MDR decision shall deliver a copy of the request 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 §141.1(d).

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