



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Shamim B. Patni, MD

**Respondent Name**

New Hampshire Insurance Company

**MFDR Tracking Number**

M4-14-3309-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

July 3, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We requested a reconsideration from the insurance, Gallagher Bassett, for a claim ... for date of service 04/05/2014 in the amount of \$1600.00, for a Designated Doctor Exam. We did not receive any payment. We submitted a reconsideration request on 06/23/2014, for the balance of \$1600.00. **The denial reason(s) per original EOB are: National provider identifier missing, 20. For the reconsideration denial: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. This bill is a reconsideration of a previously reviewed bill, allowance do not reflect previous payments. 16, BL.**"

**Amount in Dispute:** \$1600.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on July 11, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

**Response Submitted by:** NA

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 5, 2014	Designated Doctor's Examination	\$1600.00	\$1600.00

#### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.10 (f) provides a list of required elements for the medical billing form.

3. 28 Texas Administrative Code §134.204 (j) explains what is required to bill and be reimbursed for an Examination of Maximum Medical Improvement and Impairment Rating (MMI/IR).
4. 28 Texas Administrative Code §133.210 explains requirements for medical documentation of health care billing.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 20 – (206) National Provider Identifier - Missing
  - 16 – (16) Claim/Service lacks information or has submission/billing error(s) which is needed for adjudication.

**Issues**

1. Did the requestor provide the required information for adjudication of the bill, including National Provider Identifier?
2. What is the correct MAR for this service?
3. Is the requestor entitled to reimbursement?

**Findings**

1. Per 28 Texas Administrative Code §133.10 (f)(1)(L), “(1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers’ compensation health care: (L) referring provider’s National Provider Identifier (NPI) number (CMS-1500/field 17b) is required when CMS-1500/field 17 contains the name of a health care provider eligible to receive an NPI number”. CMS-1500/field 17 shows the “referring provider or other source” as “Houston West DWC”. Houston West DWC is not a health care provider eligible to receive an NPI number. Therefore, no NPI number is required in CMS-1500/field 17b.

Per 28 Texas Administrative Code §133.10 (f)(1)(V), “(V) rendering provider’s NPI number (CMS-1500/field 24j, unshaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33 and the rendering provider is eligible for an NPI number”. The rendering provider is the same as the billing provider. Therefore, no NPI number is required in CMS-1500/field 24j, although it is provided.

Per 28 Texas Administrative Code §133.10 (f)(1)(DD), “(DD) billing provider’s NPI number (CMS-1500/field 33a) is required when the billing provider is eligible for an NPI number”. The billing provider’s NPI number is present in CMS-15/field 33a.

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. (-b-) \$150 for each additional musculoskeletal body area.” The submitted documentation indicates that the Designated Doctor performed a full physical evaluation with range of motion for the cervical and lumbar spine, as well as the right shoulder, to find the Impairment Rating. Therefore, the correct MAR for this examination is \$450.00.

Per 28 Texas Administrative Code §127.10 (d), “...If a designated doctor is simultaneously requested to address MMI and/or impairment rating and the extent of the compensable injury in a single examination, the designated doctor shall provide multiple certifications of MMI and impairment ratings that take into account each possible outcome for the extent of the injury...If the designated doctor provided multiple certifications of MMI and impairment ratings, the designated doctor must file a Report of Medical Evaluation under §130.1(d) of this title for each impairment rating assigned and a Designated Doctor Examination Data Report pursuant to §127.220 of this title (relating to the Designated Doctor Reports) for the doctor’s extent of injury determination...” Furthermore, 28 Texas Administrative Code §134.204 (j)(4)(B) states, “When multiple IRs are required as a component of a designated doctor examination ... 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.” The submitted documentation indicates that the Designated Doctor was ordered to address Maximum Medical Improvement, Impairment Rating, and Extent of Injury. The narrative report and enclosed forms support that these examinations were performed, and one additional impairment rating was provided appropriately. Therefore, the correct MAR for this service is \$50.00.

Per 28 Texas Administrative Code §134.204 (k), “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.” Furthermore, 28 Texas Administrative Code §134.204 (i)(2) states, “When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection: (A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section; (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and (C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section.” The submitted documentation indicates that the Designated Doctor performed examination to determine Extent of Injury, Return to Work, and Other Similar Issues, as ordered by the Division. Therefore, the correct MAR for these examinations is \$875.00.

The correct MAR for the entire Designated Doctor's Examination is \$1725.00.

- 3. Review of the submitted documentation finds that the provider included a copy of the examination, consultation with the injured employee, review of the records and films, narrative report, and tests used to assign the IR, as required by 28 Texas Administrative Code §134.204 (j)(1).

Per 28 Texas Administrative Code §133.210 (b) states, “When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents.” Included in the submitted documentation were the Report of Medical Evaluation (DWC069), Work Status Report (DWC073), and Designated Doctor Examination Data Report (DWC068).

The requestor billed \$1600.00 for the entire examination. Review of the submitted documentation finds that the insurance carrier reimbursed \$0.00. Therefore, reimbursement of \$1600.00 is due for the examinations of Maximum Medical Improvement, Impairment Rating, Extent of Injury, Return to Work, and Other Similar Issues.

**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 \$1600.00.

**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 \$1600.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

Laurie Garnes  
Medical Fee Dispute Resolution Officer

December 19, 2014  
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.**