



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

Juan M. Villafani, MD

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-14-3637-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

August 12, 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 06/12/2014 in the amount of \$650.00, for a Designated Doctor exam. We did received a partial payment of \$500.00. We submitted a reconsideration request on 06/29/2014, for the balance of \$150.00."

Amount in Dispute: \$150.00

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 August 20, 2014. No written position statement has been received.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 12, 2014	Designated Doctor Exam to Determine Maximum Medical Improvement and Impairment Rating	\$150.00	\$150.00

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 §134.204 (j)(3)(C) provides the MAR for evaluation of Maximum Medical Improvement.
- 28 Texas Administrative Code §134.204 (j)(4)(C)(ii) provides the MAR for evaluation of Impairment Rating for musculoskeletal body areas.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 20 – (206) National Provider Identifier - Missing
 - P1 - Unexplained
 - State Specific EOB Messages: Unless otherwise noted, all reductions are due to charges exceeding the Texas Official Medical and/or Pharmaceutical Fee Guidelines allowance.

Issues

1. Did the requestor exceed the Texas Medical Fee Guideline?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(3)(C), “(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**” [emphasis added]. The provider is not the treating doctor and used the correct billing code. Therefore, reimbursement for the evaluation of MMI is found to be \$350.00.

Per 28 Texas Administrative Code §134.204 (j)(4)(C)(ii), “(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. (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**” [emphasis added]. The provider evaluated one musculoskeletal body part (right knee) and performed a full physical evaluation, with range of motion. Therefore, reimbursement for the evaluation of IR is found to be \$300.00.

The provider correctly billed \$650.00 for the combined evaluation of MMI and IR.

2. The insurance carrier reimbursed \$500.00 for the combined evaluation of MMI and IR. Review of the submitted documentation finds that the requestor is entitled to additional reimbursement.

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 \$150.00.

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 \$150.00 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 3, 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.