



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

Arthur Uehlinger, Jr., DC

**Respondent Name**

New Hampshire Insurance Company

**MFDR Tracking Number**

M4-14-3789-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

August 29, 2014

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Please accept the following Position Statement as required by Rule 133.307 (C)(2)(f).

**(F) a position statement of the disputed issue(s) that shall include:**

**(i) a description of the health care for which payment is in dispute,**

DESIGNATED DOCTOR EXAM

**(ii) the requestor's reasoning for why the disputed fees should be paid or refunded,**

CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS

**(iii) how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues, and**

THE CURRENT RULES ALLOW REIMBURSEMENT

**(iv) how the submitted documentation supports the requestor position for each disputed fee issue;**

AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

**Amount in Dispute:** \$1150.00

### **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 September 8, 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
March 28, 2014	Designated Doctor Examination	\$1150.00	\$1150.00

## **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 §133.10 sets out the procedures for billing medical care expenses.
3. 28 Texas Administrative Code §133.210 explains the documentation required for submission with medical billing.
4. 28 Texas Administrative Code §127.220 explains the requirements for a Designated Doctor's report.
5. 28 Texas Administrative Code §130.1 (d) explains the requirements for reporting certification of Maximum Medical Improvement and Impairment Rating.
6. 28 Texas Administrative Code §134.204 sets out the procedures for billing and reimbursement of Designated Doctor Examinations.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 16 – (16) Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

### **Issues**

1. Did the requestor submit all required documentation or have billing errors for the services in question?
2. What is the total allowable for the requested services?

### **Findings**

1. Review of the submitted documentation finds that the requestor billed on a CMS-1500 form and all required elements are present according to 28 Texas Administrative Code §133.10 (f). Documentation also supports that the correct CPT Code and modifiers were used as defined in 28 Texas Administrative Code §134.204 (i), (j), and (k).

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." Review of the submitted documentation supports inclusion of the Report of Medical Evaluation (DWC069) and narrative as defined in 28 Texas Administrative Code §127.220 (a) and (b), and in 28 Texas Administrative Code §130.1 (d). The submitted documentation also supports inclusion of the Work Status Report (DWC073) as required in 28 Texas Administrative Code §134.204 (k).

Therefore, the Division finds that the requestor did submit all required documentation and had no billing errors for the services in question.
2. Per 28 Texas Administrative Code §134.204 (j)(3)(C), "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." The Designated Doctor performed an examination for Maximum Medical Improvement, as ordered by the Division. Therefore, the allowable reimbursement for this examination is \$350.00  

Per 28 Texas Administrative Code §134.204 (j)(4)(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 narrative report submitted by the requestor states, "A full physical examination with range of motion was performed and resulted in 0% impairment..." Therefore, the allowable reimbursement for this examination is \$300.00.

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... 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." The narrative report submitted by the requestor states, "...the restrictions sanctioned from February 16, 2014 to March 28, 2014 were necessary...the examinee is able to return to work without restrictions from this date forward." This indicates that the doctor performed the examination for Return to

Work as ordered by the Division. Therefore, the allowable reimbursement for this examination is \$500.00.  
The total recommended reimbursement, based on the allowable amounts is \$1150.00.

**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 \$1150.00.

**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 \$1150.00 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 19, 2014
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.**