**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**
Mark Schulz, DC

**Respondent Name**
AAA Cooper Transportation

**MFDR Tracking Number**
M4-15-0628-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
October 15, 2014

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "THIS IS A DESIGNATED DOCTOR EXAM TO DETERMINE EXTENT/DISABILITY & CANNOT BE DENIED IN FULL"

**Amount in Dispute:** $806.06

## *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 October 23, 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 7, 2014 | Designated Doctor Examination | $806.06 | $806.06 |

## *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 §134.600 sets out the requirements for preauthorization.
3. 28 Texas Administrative Code §134.204 sets out the procedures for billing and reimbursement of Designated Doctor Examinations.
4. 28 Texas Administrative Code §127.10 (c) gives authority to the Designated Doctor to perform additional testing.

5. Texas Labor Code §408.0041 explains the provisions regarding Designated Doctor Examinations.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
   - 216 – Based on the findings of a review organization.
   - 219 – Based on extent of injury
   - W3 – Additional payment made on appeal/reconsideration.

**Issues**

1. Are the disputed services subject to medical necessity or extent of injury denials by the insurance carrier?
2. Is the requestor entitled to reimbursement?

**Findings**

1. Texas Labor Code §408.0041 (a) states, "At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about: …(3) the extent of the employee's compensable injury; (4) whether the injured employee's disability is a direct result of the work-related injury;…" Submitted documentation supports that the requestor was ordered by the commissioner through the Division of Workers' Compensation to perform an examination to determine the extent of the injury and whether the injured employee's disability was a direct result of the work-related injury.

   Further, 28 Texas Administrative Code §127.10 (c) states, "The designated doctor shall perform additional testing when necessary to resolve the issue in question…**Any additional testing or referral required for the evaluation is not subject to preauthorization requirements nor shall those services be denied retrospectively based on medical necessity, extent of injury, or compensability** in accordance with the Labor Code §408.027 and §413.014, Insurance Code Chapter 1305, or Chapters 10, 19, 133, or 134 of this title" [emphasis added].

   Therefore, the examinations to determine extent of injury, disability, and the testing required to answer these questions are not subject to medical necessity or extent of injury denials by the insurance carrier.
2. 28 Texas Administrative Code §134.204 (i)(1) states, "Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and **shall be billed and reimbursed** as follows: …(C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier 'W6;' (D) Whether the injured employee's disability is a direct result of the work-related injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier 'W7;'…(2) 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" [emphasis added].

   Further, 28 Texas Administrative Code §134.204 (k) states, "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**" [emphasis added].

   Therefore, the recommended reimbursement for billed CPT Code 99456 with modifiers W6 and RE is $500.00. The recommended reimbursement for billed CPT Code 99456 with modifiers W7 and RE is $250.00.

   The additional testing, billed CPT Code 95851, service date April 7, 2014, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.16 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 0.16224. The practice expense (PE) RVU of 0.33 multiplied by the PE GPCI of 1.013 is 0.33429. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.803 is 0.00803. The sum of 0.50456 is multiplied by the Division conversion factor of $55.75 for a MAR of $28.13 at 2 units is $56.26. The requestor is seeking additional reimbursement in the amount of $56.06. This amount 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 $806.06.

## *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 $806.06 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| | | |
|---|---|---|
| | | January 22, 2015 |
| 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**.