



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

Dennis J. Roberts, DC

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-15-1009-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

November 26, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I received an EOB denying partial payment for this bill; the denial states 'PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES; WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT'. However, this denial is incorrect, since the payment made did not meet the amount suggested for payment by the Medical Fee Guidelines.

99456-W6-RE was used because Dr. Roberts is a designated doctor performing an examination that addressed the extent of compensable injury (as requested on the DWC-32 form...).

98951 was used to bill the range of motion measurements taken by Dr. Roberts in order to determine the extent of injury.

We billed a total of \$1,200.00 for these services. *We have only received \$381.08 from your company, which does not meet the Medical Fee Guidelines suggested payment amount. Please issue prompt payment in the amount of \$818.92 to settle this claim.*"

Amount in Dispute: \$118.92

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 December 4, 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 23, 2014	Designated Doctor Examination (EOI)	\$118.92	\$118.92

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 and denial of medical bills.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for billing and reimbursing professional medical services.
4. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – Workers Compensation State Fee Schedule Adjustment
 - 59 – Processed based on multiple or concurrent procedure rules.
 - P1 – Not defined as required in 28 Texas Administrative Code §133.240.
 - P12 – Workers' compensation jurisdictional fee schedule adjustment.
 - ZE10 – Not defined as required in 28 Texas Administrative Code §133.240.

Issues

1. What is the correct MAR for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 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**" [emphasis added].

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 an examination to determine Extent of Injury. Therefore, the correct MAR for this examination is \$500.00.

Procedure code 95851, service date April 23, 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 1.004 is 0.33132. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.939 is 0.00939. The sum of 0.50295 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$28.04 at 2 units is \$56.08.

2. The total allowable for the disputed services is \$556.08. Review of the submitted documentation finds that the insurance carrier paid \$381.08. This leaves a balance of \$175.00. The requestor is seeking \$118.92. Therefore, the division recommends an additional reimbursement of \$118.92.

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 \$118.92.

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 \$118.92 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

April 21, 2015
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.