



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

David C. Baugher, D.C.

**Respondent Name**

ACE American Insurance Company

**MFDR Tracking Number**

M4-15-1074-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

December 5, 2014

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "... they have used the tier payment out of context. Originally, Dr. Baugher examined this injured employee on 08/12/2013 and found him not at MMI and unable to return to work. Nine months later we received a New Order for the same issues and the injured employee was then on 5/20/2014 found at MMI, given an impairment rating and returned to work."

**Amount in Dispute:** \$175.00

### 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 December 15, 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.

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 20, 2014	Designated Doctor Examination	\$175.00	\$100.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 §134.204 sets out the fee guidelines for Division-specific services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 59 – Processed based on multiple or concurrent procedure rules.

### Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

### Findings

1. The insurance carrier reduced disputed services with claim adjustment reason code 59 – "PROCESSED BASED ON MULTIPLE OR CONCURRENT PROCEDURE RULES." 28 Texas Administrative Code §134.204 (i)(2) states,

When multiple examinations **under the same specific Division order** [emphasis added] are performed concurrently under **paragraph (1)(C) - (F)** [emphasis added] 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.

28 Texas Administrative Code §134.204 (i)(1)(C)-(F) includes examinations for extent of injury, whether the injured employee's disability is a direct result of the work-related injury, the ability of the employee to return to work, and similar issues, but does not include maximum medical improvement or impairment rating.

Review of the submitted information finds that the disputed services includes only one examination subject to the tiered reimbursement guidelines found in 28 Texas Administrative Code §134.204 (i)(2). This examination is paid at 100 percent in accordance with (2)(A) of this subsection. The insurance carrier's reduction reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

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 requestor performed an evaluation of Maximum Medical Improvement. 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." The submitted documentation indicates that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the right lower extremity. Therefore, the correct MAR 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. 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.

The submitted documentation indicates that the Designated Doctor performed an examination to determine the ability of the injured employee to return to work. Therefore, the correct MAR for this examination is \$500.00.

3. The total MAR for the disputed services is \$1150.00. The insurance carrier paid \$1050.00. An additional reimbursement of \$100.00 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 \$100.00.

***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 \$100.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

	Laurie Garnes	November 17, 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, 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 MFDR 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.**