



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

Rick Cazares, DC

Respondent Name

Zurich American Insurance Company

MFDR Tracking Number

M4-15-1155-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

December 15, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I received a partial payment for this bill; the EOB denied the balance stating 'WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT; PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.' However, this is incorrect. The payment issued to us does not meet the MFG recommended allowance.

99456-W5-WP was the CPT code & modifiers used because: a doctor other than the treating doctor examined the injured worker; the doctor was acting as a TDI-DWC appointed designated doctor; the exam performed by the doctor was to determine MMI and IR; the injured employee is at MMI; the designated doctor is billing for the whole procedure of impairment rating measurements; the doctor is eligible for 100% of the MAR for the exam.

...

This was a bill for a division-ordered Designated Doctor Examination with the purpose of determining the injured worker's Impairment Rating (IR), Maximum Medical Improvement (MMI), Extent of Injury, 'Other,' and Multiple Certifications ...

We billed a total of \$3,750.00 for these services. *We have only received \$1,200.00 from your company.*"

Amount in Dispute: \$100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The DWC-60 filed by Dr. Cazares regarding date of service June 6, 2014 requests review of a reduction of a fee in connection with providing a designated doctor exam on the issues of MMI, impairment rating, and extent of injury. The portion of services billed under Code 99456 W5 WP was reviewed and appropriately reimbursed in the amount of \$300.00 as indicated on the EOB dated August 6, 2014. The billed amount of \$1,200.00 for this service was adjusted in accordance with the Workers' Compensation Jurisdictional Fee Schedule. 28 TAC 134.201, *et seq.* The disputed fee of \$100.00 should not be paid because the amount sought is in excess of the fee guidelines."

Response Submitted by: Knott & Doyle

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 6, 2014	Designated Doctor Examination (IR)	\$100.00	\$100.00

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 §134.204 sets out the fee schedule for billing and reimbursing Designated Doctor Examinations performed after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
 - 247 – A payment or denial has already been recommended for this service.
 - 947 – R03 – Upheld – No additional allowance has been recommended.

Issues

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

Findings

1. The insurance carrier references Rule §134.202(e)(6)(D)(iii) in their position statement. 28 Texas Administrative Code §134.204 (a) states, "Applicability of this rule is as follows: (2) This section applies to workers' compensation specific codes, services and programs provided on or after March 1, 2008." This dispute involves services provided June 6, 2014. Therefore, the applicable rule for resolution of the disputed services is 28 Texas Administrative Code §134.204.
2. 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. (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (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 Designated Doctor performed a full physical evaluation with range of motion for the lower extremities to find the Impairment Rating and the DRE method was used for the cervical spine to find the Impairment Rating. Therefore, the correct MAR for this examination is \$450.00.
3. The total allowable for the services in dispute is \$450.00. Review of the submitted documentation finds that the insurance carrier paid \$300.00. The requestor is entitled to additional reimbursement of \$150.00. The requestor is seeking \$100.00. Therefore, 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

Signature

Laurie Garnes

Medical Fee Dispute Resolution Officer

March 3, 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.