



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

Sandra Silmon, DC

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-15-1274-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

December 29, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Texas Mutual on 9/18/14, this request was in response to a \$150.00 reduction of the \$1165.00 for the Designated Doctor Exam performed on 06/27/14. Unfortunately our request was denied and we are seeking the balance owed to us.

The denial reason(s) per EOB are: Workers Compensation fee schedule adjustment. Designated Doctor Exams are billed according to DWC rule 134.204 and in accordance with labor code 408.004, 408.0041, and 408.151."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute 11/23/2013 and 6/27/2014.

1. Texas Mutual has elected to pay the requested additional amount of \$150.00 for date 6/27/14.
2. Rule 133.307(c)(1)(A) states, '...A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute. (B) A request may be filed later than one year after the date(s) of service if: (i) a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability; (ii) a medical dispute regarding medical necessity has been filed, the medical fee dispute must be filed not later than 60 days after the date the requestor received the final decision on medical necessity, inclusive of all appeals, related to the health care in dispute and for which the insurance carrier previously denied payment based on medical necessity; or (iii) the dispute relates to a refund notice issued pursuant to a division audit or review, the medical fee dispute must be filed not later than 60 days after the date of the receipt of a refund notice. Texas Mutual reviewed its claim file and found (B)(i-iii) do not apply.'
3. One year from disputed date 11/23/13 is 11/23/14. The TDI/DWC date stamp lists the received date as 12/29/14 on the requestor's DWC-60 packet, a date greater than one year from 11/23/13. The requestor has waived its right to DWC MDR for this date of service."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 23, 2013 & June 27, 2014	Work Status Report & Designated Doctor Examination (MMI/IR)	\$150.00	\$0.00

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 guidelines for billing and reimbursing Designated Doctor Examinations.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
 - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
 - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 724 – No additional payment after a reconsideration of services.
 - 920 – Reimbursement is being allowed based upon a dispute.

Issues

1. Did the requestor waive the right to Medical Fee Dispute Resolution for the disputed services?
2. What is the correct MAR for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the services in dispute are November 23, 2013 and June 27, 2014. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on December 29, 2014. This date is later than one year after the November 23, 2013 date of service in dispute. Review of the submitted documentation finds that these disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file the dispute for this date of service with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution and this date of service will not be considered. The Division finds that date of service June 27, 2014 was timely filed and the issues regarding this date of service will be considered.
2. The disputed services for June 27, 2014 involve a Designated Doctor Examination to determine Maximum Medical Improvement, Impairment Rating, and the ability of the injured employee to return to work.

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 Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. 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 Designated Doctor performed a full physical evaluation with range of motion for the lumbar spine to find the correct Diagnosis Related Estimate chart to determine Impairment Rating. 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 allowable for the November 27, 2014 disputed services is \$1150.00. Review of the submitted documentation finds that the insurance carrier paid a total of \$1150.00 with applicable interest. Therefore, no further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

April 7, 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.