



# 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**

Lorry Thornton, DO

**Respondent Name**

New Hampshire Insurance Company

**MFDR Tracking Number**

M4-15-2467-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

April 10, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Dr. Lorry Thornton requests Medical Dispute Resolution in pursuant of Rule 133.305 Medical Dispute Resolution in the above referenced patient's case..."

New Rule §134.204(i) describes all six examinations performed by designated doctors, but directs the reimbursement for MMI/IR examinations performed by designated doctors to subsection (j), and excludes reimbursement for MMI/IR from the tiered reimbursement structure of subsection (i) for multiple examinations performed by the designated doctor. MMI/IR examinations performed by designated doctors do not result in the tiering of the non-MMI/IR examinations.

When conducting exams for issues other than MMI/IR, apply the new tiered reimbursement method described in rule 134.204(i) to the remaining four exams under the same request, the first exam is reimbursed at 100% of the fee for the exam, \$500; the second exam is reimbursed at 50% of the fee for the exam, \$250; and the subsequent exam(s) are reimbursed at 25% of the fee for the examination, \$125..."

**Amount in Dispute:** \$250.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Please see the EOBs for explanation regarding the bill reduction. The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011(d). Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

**Response Submitted by:** Flahive, Ogden & Latson

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 12, 2014	Designated Doctor Examination (MMI/IR, EOI, RTW) Work Status Report	\$250.00	\$250.00

## **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 billing and reimbursing Designated Doctor Examinations.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 217 – The value of this procedure is included in the value of another procedure performed on this date.
  - 97 – Payment is included in the allowance for another service/procedure.

### **Issues**

1. Is the insurance carrier's denial for payment of the disputed services supported?
2. What is the correct Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

### **Findings**

1. The insurance carrier denied disputed CPT Codes 99456-W8-RE with claim adjustment reason code 217 – "TX The value of this procedure is included in the value of another procedure performed on this date." 28 Texas Administrative Code §134.204 does not indicate that the value of this code is included in the value of any other billed codes for the date of service in question. This denial reason presented by the insurance carrier is not supported. Therefore the disputed services shall be reviewed according to 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 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" [emphasis added]. The submitted documentation indicates that the Designated Doctor performed a full physical evaluation with range of motion for the left upper extremity to find the Impairment Rating. Further, 28 Texas Administrative Code §134.204 (j)(4)(C) states, "(iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier '26.' Reimbursement shall be 80 percent of the total MAR. (v) If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier 'TC.' In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR." Therefore, the correct MAR for the examining doctor for this examination is \$240.00. The correct MAR for the health care provider performing the range of motion, sensory, or strength testing is \$60.00.

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."

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 examinations to determine Extent of Injury and Return to Work as ordered by the Division. Therefore, the correct MAR for the examination to determine Extent of Injury is \$500.00 and the correct MAR for the examination to determine the injured employee’s ability to Return to Work is \$250.00.

Per 28 Texas Administrative Code §134.204 (l), “The following shall apply to Work Status Reports. When billing for a Work Status Report **that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section** [emphasis added], refer to §129.5 of this title (relating to Work Status Reports)”. Therefore, the filing of the DWC-073 is not payable when provided in conjunction with a Designated Doctor Examination under 28 Texas Administrative Code §134.204 (i).

- 3. The total MAR for 99456-W5-26 is \$590.00 (Total MMI + 80% of IR). The insurance carrier paid \$650.00. Therefore, no additional reimbursement is recommended for this code.

The total MAR for 99456-W5-TC is \$60.00 (20% of IR). The insurance carrier paid \$0.00. The requestor is seeking \$0.00. Therefore, no additional reimbursement is recommended for this code.

The total MAR for 99456-W6-RE is \$500.00. The insurance carrier paid \$500.00. Therefore, no additional reimbursement is recommended for this code.

The total MAR for 99456-W8-RE is \$250.00. The insurance carrier paid \$0.00. The requestor is seeking \$250.00. Therefore, an additional reimbursement of \$250.00 is recommended.

The total MAR for 99080-73 is \$0.00. The insurance carrier paid \$15.00. Therefore, no additional reimbursement is recommended for this code.

**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 \$250.00.

***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 \$250.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

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Signature

Laurie Garnes  
Medical Fee Dispute Resolution Officer

May 15, 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, 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.**