



# 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**

Russell Juno, MD

**Respondent Name**

New Hampshire Insurance Company

**MFDR Tracking Number**

M4-15-2545-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

April 13, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We submitted a request for reconsideration to Gallagher Bassett on August 1, 2014, this request was in response to a nonpayment of the \$1465.00 for the Designated Doctor Exam performed on April 18, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

**Amount in Dispute:** \$1465.00

### 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 April 21, 2015. 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
April 18, 2014	Designated Doctor Examination (MMI/IR/EOI/RTW)	\$1465.00	\$1450.00

### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Designated Doctor Examinations.

3. 28 Texas Administrative Code §133.240 sets out the procedures for payment and denial of medical bills.
4. 28 Texas Administrative Code §133.10 defines the required fields on professional medical billing.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 20 – (206) National Provider Identifier – missing
  - F624 – Not defined as required in 28 Texas Administrative Code §133.240

### **Issues**

1. Are the insurance carrier’s reasons for denial or 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 denied disputed services with claim adjustment reason code “20 – (206) National Provider Identifier – missing.” Per 28 Texas Administrative Code §133.10 (f)(1)(L), “(1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers’ compensation health care: (L) referring provider’s National Provider Identifier (NPI) number (CMS-1500/field 17b) is required when CMS-1500/field 17 contains the name of a health care provider eligible to receive an NPI number”. CMS-1500/field 17 shows that there is no referring health care provider. Therefore, no NPI number is required in CMS-1500/field 17b.

Per 28 Texas Administrative Code §133.10 (f)(1)(V), “(V) rendering provider’s NPI number (CMS-1500/field 24j, unshaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33 and the rendering provider is eligible for an NPI number”. The rendering provider is the same as the billing provider. Therefore, no NPI number is required in CMS-1500/field 24j, although it is provided.

Per 28 Texas Administrative Code §133.10 (f)(1)(DD), “(DD) billing provider’s NPI number (CMS-1500/field 33a) is required when the billing provider is eligible for an NPI number”. The billing provider’s NPI number 1275577538 is present in CMS-15/field 33a. Per the National Plan and Provider Enumeration System at <https://nppes.cms.hhs.gov>, this number was valid for the billing provider on the date of service.

The insurance carrier’s denial 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 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 Impairment Rating. Therefore, the correct MAR for this examination is \$300.00.

28 Texas Administrative Code §134.204 (j)(4)(B) states, “When multiple IRs are required as a component of a designated doctor examination ... the designated doctor shall bill for the number of body areas rated and be reimbursed \$50 for each additional IR calculation. Modifier ‘MI’ shall be added to the MMI evaluation CPT code.” The submitted documentation indicates that the Designated Doctor was ordered to address Maximum Medical Improvement, Impairment Rating, and Extent of Injury. The narrative report and enclosed forms support that these examinations were performed, and multiple impairment ratings were provided appropriately. Therefore, the correct MAR for this service is \$50.00.

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, Return to Work as ordered by the Division. The correct MAR for the Extent of Injury examination is \$500.00. The correct MAR for the Return to Work examination 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 performed according to 28 Texas Administrative Code §134.204 (i).

3. The total allowable for the disputed services is \$1450.00. The insurance carrier paid \$0.00. A reimbursement of \$1450.00 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 \$1450.00.

### ***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 \$1450.00 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

June 11, 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.**