



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

Gregory P. Ennis, MD, PA

Respondent Name

Standard Fire Insurance Company

MFDR Tracking Number

M4-15-2772-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

April 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... EcCare Health Centers correctly reads TAC 28 par 2, 134.204 and the amount of \$827.00 is due and payable for an examination by the treating physician to determine MMI and to assign IR's to three musculoskeletal body areas with ROM and DRE methods.

... Reimbursement under TAC 28 part 2 for 2014 is , \$226.19 for MMI by treating physician, \$300.00 for first IR by ROM, \$150 for second IR by ROM and \$150 for IR by DRE method. (\$826.19).

EcCare Health Centers states that the amount of \$292.33 is past due payable..."

Amount in Dispute: \$293.14

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "... we have escalated the bill in question for manual review to determine if additional monies are owed.

Supplemental response will be provided once the billing auditing company has finalized their review..."

Response Submitted by: Gallagher Bassett Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 3, 2014	Treating Doctor Examination to Determine MMI/IR	\$293.14	\$36.14

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.

2. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers’ Compensation jurisdictional fee schedule adjustment

Issues

1. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier based reduction of the disputed services on claim adjustment reason code “P12 – Workers’ Compensation jurisdictional fee schedule adjustment.” Per 28 Texas Administrative Code §134.204 (j)(3), “The following applies for billing and reimbursement of an MMI evaluation. (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier. (i) Reimbursement shall be the applicable established patient office visit level associated with the examination. (ii) Modifiers ‘V1’, ‘V2’, ‘V3’, ‘V4’, or ‘V5’ shall be added to the CPT code to correspond with the last digit of the applicable office visit.”

Review of the submitted documentation finds that the requestor seeks reimbursement for CPT Code 99455-V5-WP. Therefore, the MMI portion of this code corresponds with 99215 as the applicable office visit. Reimbursement for this code is determined by 28 Texas Administrative Code §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 2.11 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 2.13954. The practice expense (PE) RVU of 1.79 multiplied by the PE GPCI of 1.013 is 1.81327. The malpractice RVU of 0.13 multiplied by the malpractice GPCI of 0.803 is 0.10439. The sum of 4.0572 is multiplied by the Division conversion factor of \$55.75 for a MAR of \$226.19.

Further, 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... (D)... (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.”

Review of the submitted documentation finds that the requestor performed a full physical evaluation with range of motion for the left upper extremity to find the Impairment Rating. The MAR for this examination is \$300.00. Documentation also supports that the requestor performed an evaluation to determine the impairment rating of the neck using the DRE method found in the AMA Guides 4th edition. The MAR for this examination is \$150.00. Further, the impairment of the chest wall is discussed in Chapter 5 of the AMA Guides 4th edition (relating to the Respiratory System). Therefore, this impairment is paid under the non-musculoskeletal category of body systems. The MAR for this examination is \$150.00. Therefore, the total MAR for the examination to determine Impairment Rating is \$600.00.

2. The total allowable for the disputed services is \$826.19. Review of the submitted documentation finds that the insurance carrier paid a total of \$790.05. Therefore, an additional reimbursement of \$36.14 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 \$36.14.

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 \$36.14 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	<u>Laurie Garnes</u>	<u>June 9, 2015</u>
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.