



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

Ruth E. Carter, DO

Respondent Name

Bexar County

MFDR Tracking Number

M4-15-2820-01

Carrier's Austin Representative

Box Number 29

MFDR Date Received

May 1, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Tristar on 8-27-14, this request was in response to a \$450.00 reeducation of the \$1650.00 for the DDE performed on 5-28-14. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: \$450.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the submitted documentation no additional payment is being made at this time. Upon review, the submitted bill was paid correctly per the fee schedule and guidelines."

Response Submitted by: IMO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 28, 2014	Designated Doctor Examination	\$450.00	\$0.00

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.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 219 – Based on extent of injury
 - 18 – Exact duplicate claim/service
 - This procedure on this date was previously reviewed

Issues

1. What are the services in dispute?
2. Are the insurance carrier's reasons for denial or reduction of payment supported?
3. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. While the requestor included charges for multiple impairments and an examination for extent of injury on the Medical Fee Dispute Resolution Request (DWC060), the requestor is seeking \$0.00 for these services. Therefore, these services will not be considered. The requestor is seeking an additional reimbursement of \$450.00 for an examination to determine maximum medical improvement and impairment rating for date of service May 28, 2014.
2. The insurance carrier denied disputed services with claim adjustment reason code "219 – Based on extent of injury." Review of the submitted information finds that the Division ordered a designated doctor examination to evaluate maximum medical improvement, impairment rating, and extent of injury. The compensable injuries defined by the insurance carrier on the Request for Designated Doctor (DWC032) are cervical strain, thoracic strain, and lumbar strain. The conditions requested for review for extent of injury are sinonasal polyposis, sinusitis, arthritis, degenerative, and preexisting conditions. The submitted narrative report indicates that these are the only conditions reviewed by the requestor. Therefore, the insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
3. 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 requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is \$350.00.

28 Texas Administrative Code §134.204(j)(4) states, in relevant part:

The following applies for billing and reimbursement of an IR evaluation.

- (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The **number of body areas rated** [emphasis added] shall be indicated in the units column of the billing form.
- (B) ...
- (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
 - (i) Musculoskeletal body areas are defined as follows:
 - (I) spine and pelvis;
 - (II) upper extremities and hands; and,
 - (III) lower extremities (including feet).
 - (ii) The MAR for musculoskeletal body areas shall be as follows:
 - (I) ...
 - (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area; and (-b-) \$150 for each additional musculoskeletal body area.

The submitted documentation indicates that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the spine. Therefore, the correct MAR for this examination is \$300.00.

4. The total MAR is \$650.00 for the disputed services. The insurance carrier paid \$650.00. 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

November 18, 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.