



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

Ramesh D. Shah, MD

Respondent Name

ACIG Insurance Company

MFDR Tracking Number

M4-15-2839-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

May 4, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I received an EOB denying payment of this bill, which states: 'DUPLICATE CLAIM/SERVICE; DUPLICATE BILLING.'

However, this is incorrect, since we have submitted this bill only one time on February 11, 2014 via fax..."

Amount in Dispute: \$1050.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "...Please note CorVel has not received a request for reconsideration for date of service 11/13/14 in accordance with DWC rule §133.250 to date. As such, CorVel respectfully requests the division issue a decision dismissing the request for MFDR in accordance with §133.307 (f)(3)(A)..."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: November 13, 2014, Designated Doctor Examination (MMI/IR/EOI), \$1050.00, \$1050.00

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 guidelines for billing and reimbursing Designated Doctor Examinations.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 18 – Duplicate Claim/Service
• R1 – Duplicate Billing

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 on Explanations of Benefits dated February 19, 2015 and April 3, 2015 with claim adjustment reason code "18 – Duplicate Claim/Service." 28 Texas Administrative Code §133.307 (d)(2) states, in relevant part, "Response. Upon receipt of the request, the respondent shall provide any missing information not provided by the requestor and known to the respondent. The respondent shall also provide the following information and records: ... (B) a paper copy of all initial and appeal EOBs related to the dispute, as originally submitted to the health care provider in accordance with this chapter, related to the health care in dispute not submitted by the requestor."

Review of the submitted information does not find documentation to support that an earlier Explanation of Benefits was issued to cause the submissions included in this dispute to be duplicated. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. This dispute involves a Designated Doctor Maximum Medical Improvement (MMI) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(3), which states that "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.

This dispute involves a Designated Doctor Impairment Rating (IR) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4)(D)(v), which states, "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 impairment rating evaluations of a psychological condition. Therefore, the MAR for this assessment is \$150.00.

This dispute involves a Designated Doctor evaluation to determine the Extent of Injury, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204 (k), which states, "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 Extent of Injury. Therefore, the correct MAR for this examination is \$500.00.

This dispute involves the assessment of Multiple Impairment Ratings, with reimbursement subject to 28 Texas Administrative Code §134.204 (j)(4)(B), which 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.

The requestor is seeking \$0.00 reimbursement for CPT Code 99456-SP, so this code will not be considered.

3. The total allowable for the disputed services is \$1050.00. The insurance carrier paid \$0.00. Therefore, a reimbursement of \$1050.00 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 \$1050.00.

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 \$1050.00 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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|-----------|--|--------------|
| | Laurie Garnes | June 4, 2015 |
| 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.