



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

John D. Kirkwood, D.O.

Respondent Name

American Zurich Insurance Company

MFDR Tracking Number

M4-15-2887-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... the doctor performed an evaluation of Maximum Medical Improvement and Impairment Ratings for four (4) body areas – one (1) musculoskeletal body areas with range of motion ROM upper extremities, one (1) musculoskeletal body areas with diagnosis related estimate DRE spine & pelvis, and two (2) non-musculoskeletal body of (1) non-musculoskeletal body area with diagnosis related estimate DRE body structures, (1) non-musculoskeletal body area with diagnosis related estimate DRE mental and behavioral disorders for total allowable of \$1,100.00. The insurance carrier paid \$950.00.

I am requesting reimbursement for an additional \$150.00, for a total reimbursement of \$1,100.00."

Amount in Dispute: \$150.00

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 bill auditing company has finalized their review."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 29, 2014, Referral Doctor Examination to Determine MMI/IR, \$150.00, \$150.00

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 §133.240 sets out the procedures for denying or reimbursing medical bills.
3. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P1 – Not defined as required in 28 Texas Administrative Code §133.240. Code is defined by ASC X12 External Code Source 139 as, “State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.”
 - P12 – Workers’ Compensation Jurisdictional Fee Schedule Adjustment.
 - P300 – Not defined as required in 28 Texas Administrative Code §133.240.
 - Z710 – Not defined as required in 28 Texas Administrative Code §133.240.
 - 18 – Duplicate claim/service
 - U301 – Not defined as required in 28 Texas Administrative Code §133.240.
 - Z362 – Not defined as required in 28 Texas Administrative Code §133.240.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

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

Findings

1. 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.

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), which states that “(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... (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. (D) ... (i) Non-musculoskeletal body areas are defined as follows: (I) body systems; (II) body structures (including skin); and, (III) mental and behavioral disorders. (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides... (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 impairment rating evaluations of the right shoulder, cervical/lumbar spine, right eye, and post traumatic stress disorder. Therefore the total MAR for these examinations is \$750.00. See below for more detailed information.

Examination	§134.204 Category	Reimbursement Amount
Maximum Medical Improvement		\$350.00
IR: Right Shoulder (ROM)	Upper Extremities	\$300.00
IR: Cervical/Lumbar Spine (DRE)	Spine/Pelvis	\$150.00
IR: Right Eye (Non-musculoskel)	Body Systems	\$150.00
IR: PTSD	Mental/Behavioral	\$150.00
Total MMI		\$350.00
Total IR		\$750.00
Total Exam		\$1,100.00

2. The total allowable for the disputed services is \$1100.00. The insurance carrier paid \$950.00. An additional reimbursement of \$150.00 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 \$150.00.

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 \$150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	June 24, 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.