



# 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**

Kelly Clenney, D.C.

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-15-2920-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

May 8, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** Review of the submitted documentation does not find a position statement from the requestor.

**Amount in Dispute:** \$150.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requestor placed the claimant in DRE category II. For this reason, according to Rule 134.204(j)(4)(C)(ii)(I), Texas Mutual paid the requestor \$150.00 for the DRE model found in the AMA Guides 4<sup>th</sup> edition."

**Response Submitted by:** Texas Mutual Insurance Company

### SUMMARY OF FINDINGS

| Dates of Service | Disputed Services                                   | Amount In Dispute | Amount Due |
|------------------|---|-------------------|------------|
| August 19, 2014  | Evaluation by a Referral Doctor 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**

- 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 Division-specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - CAC-P12 – Workers' Compensation Jurisdictional Fee Schedule adjustment.
  - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 891 – No additional payment after reconsideration.

**Issues**

1. What is the Maximum Allowable Reimbursement (MAR) for the disputed services, according to fee guidelines?
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.

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. (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.” The submitted documentation finds that the Designated Doctor performed a full physical evaluation with range of motion on the lumbar spine. Therefore, the correct MAR for this examination is \$300.00.

2. The total allowable for the disputed services is \$650.00. The insurance carrier paid \$500.00. Therefore, 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 §413.031, the Division has determined that the requestor is entitled to \$150.00 reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Laurie Garnes  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
June 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.**