



# 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**

Robert C. Jaehne, D.C.

**Respondent Name**

Old Republic Insurance Company

**MFDR Tracking Number**

M4-15-3224-01

**Carrier's Austin Representative**

Box Number 44

**MFDR Date Received**

June 1, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "... the payment issued to us does not meet the recommended allowance as set by the Texas Medical Fee Guidelines for the procedures billed."

**Amount in Dispute:** \$150.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on June 10, 2015. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 9, 2015	Designated Doctor Examination (MMI/IR/EOI)	\$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 §127.220 sets out the requirements for designated doctor reports.
- 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:
  - P12 – Workers’ Compensation Jurisdictional Fee Schedule adjustment.
  - 16 – Claim/service lacks information which is needed for adjudication.
  - OA – The amount adjusted is due to bundling or unbundling of services.
  - PI – There are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary. The amount adjusted is generally not the patient responsibility, unless the workers compensation state law allows the patient to be billed.
  - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
  - 247 – A payment or denial has already been recommended for this service.

### **Issues**

1. Are the insurance carrier’s reasons for denial of payment for CPT Code 99456-W6-RE 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 CPT Code 99456-W6-RE with claim adjustment reason code “16 – Claim/service lacks information which is needed for adjudication.” This code, including attached modifiers, indicates that the designated doctor performed an examination to determine the extent of the compensable injury. 28 Texas Administrative Code §134.204 (k) states, in relevant part,

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** [emphasis added].

Review of the submitted information finds that the designated doctor’s report does not include findings of the extent of the compensable injury or a Designated Doctor Examination Report in accordance with 28 Texas Administrative Code §127.220. The insurance carrier’s denial reason is supported. Additional reimbursement cannot be recommended for this code.

2. 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. ... (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area.” The submitted documentation indicates that the Designated Doctor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the upper extremities. Therefore, the correct MAR for this examination is \$300.00.

3. The total MAR for the disputed services is \$650.00. The insurance carrier paid \$500.00. Therefore, 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**

_____	<u>Laurie Garnes</u>	<u>July 30, 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.**