



# 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**

Thomas P. Burns, M.D.

**Respondent Name**

ACE American Insurance Company

**MFDR Tracking Number**

M4-15-3225-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

June 1, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "... the payment received does not meet the MFG recommended allowance for the services provided to the claimant during the examination."

**Amount in Dispute:** \$300.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "According to the designated doctor request ..., the designated doctor was to evaluate for MMI, IR and RTW. The provider is seeking ... reimbursement for extent of injury which was not requested or ordered and therefore it is our position it is not reimbursable."

**Response Submitted by:** Broadspire

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 27, 2014	Designated Doctor Examination (MMI/IR)	\$300.00	\$300.00

### 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:
  - 885 – Review of this code has resulted in an adjusted reimbursement
  - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies.

- D00 – Based on further review, no additional allowance is warranted.

### **Issues**

1. What are the disputed services?
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 states in its position statement that “The provider is seeking ... reimbursement for extent of injury which was not requested or ordered and therefore it is our position it is not reimbursable.” Review of the Medical Fee Dispute Resolution Request (DWC060) finds that the following CPT Codes are listed: 99456 W5 WP, 99456 W5 WP, 99456 W6 RE, and 99456 W8 RE. However, the only code that lists an amount in dispute is CPT Code 99456 W5 RE for \$300.00. Therefore, this will be the only code considered in this dispute.

28 Texas Administrative Code §134.204 (i)(1) states, in relevant part, “Designated Doctors shall perform examinations in accordance with Labor Code §§..., 408.0041 .... and Division rules, and shall be billed and reimbursed as follows: (A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor; (B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor.” Therefore, the services in dispute are examinations to determine the maximum medical improvement and impairment rating of the injured employee.

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. (-b-) \$150 for each additional 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 for the right shoulder and hand (upper extremity) and the right knee (lower extremity). Therefore, the correct MAR for this examination is \$450.00.

3. The total MAR for the disputed services is \$800.00. The insurance carrier paid \$500.00. Therefore, an additional reimbursement of \$300.00 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 \$300.00.

### ***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 \$300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

Laurie Garnes  
Medical Fee Dispute Resolution Officer

July 1, 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.**