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
Dennis W. Teal, D.C.

Respondent Name
Hartford Underwriters Insurance

MFDR Tracking Number
M4-15-3228-01

Carrier's Austin Representative
Box Number 47

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 set by the Texas Medical Fee Guideline."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment was processed in the amount of $1,450 per the Texas rules and regulations as outlined in Rule 134.204…

The provider only billed diagnosis code: 843.9 – Sprain hip & thigh…

… No additional reimbursement monies due to provider."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 1, 2015	Designated Doctor Examination (MMI/IR/EOI/RTW)	$50.00	$50.00

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 §133.10 sets out the guidelines to complete medical bills.
3. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Designated Doctor Examinations.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 4150 – An allowance has been paid for a Designated Doctor Examination as outlined in 134.204(j) for attainment of Maximum Medical Improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was performed.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - 851 – The allowance was adjusted in accordance with multiple procedure rules and/or guidelines.
   - 247 – A payment or denial has already been recommended for this service.
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. Did the provider submit a bill in accordance with 28 Texas Administrative Code §133.10?
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 claimed in their position statement that the disputed services were paid according to applicable fee guidelines because the provider only billed one diagnosis code. 28 Texas Administrative Code §133.10 (f)(1)(M) requires "diagnosis or nature of injury (CMS-1500/field 21) is required, **at least one diagnosis code and the applicable ICD indicator must be present.**" Review of the submitted documentation finds that the requestor included diagnosis code 843.9. Therefore, the insurance carrier's reduction reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

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 for the right hip. Therefore, the correct MAR for this examination is $300.00.

   Per 28 Texas Administrative Code §134.204 (k), "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."

   Furthermore, 28 Texas Administrative Code §134.204 (i)(2) states, "When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection: (A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section; (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and (C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section." The submitted documentation indicates that the Designated Doctor performed examinations to determine Extent of Injury and Return to Work as ordered by the Division. Therefore, the correct MAR for these examinations is $500.00 for the first examination and $250.00 for the second examination, for a total of $750.00.

Furthermore, 28 Texas Administrative Code §134.204 (j)(4)(B) 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 two additional impairment ratings were provided. Therefore, the correct MAR for this service is $100.00.

3. The total MAR for the disputed services is $1500.00. The insurance carrier paid $1450.00. Therefore, an additional reimbursement of $50.00 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 $50.00.

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 $50.00 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 23, 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.