



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

Michael Romain, M.D.

Respondent Name

City of Austin

MFDR Tracking Number

M4-15-3279-01

Carrier's Austin Representative

Box Number 43

MFDR Date Received

June 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Gallagher Bassett on January 12, 2015. This request was in response to a \$150.00 reduction of the \$1,765.00 for the DDE performed on October 18, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider examined and provided an impairment rating for only two (2) **body areas.**

... Starting on page 8 of the report submitted by the provider, the examinations performed for the MMI/IR consisted of a spinal examination and lower extremity examination which would be a total of two (2) body areas...

Based on the above information the TPA ... contends that additional reimbursement is not warranted."

Response Submitted by: York Risk Services Group

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 18, 2014	Designated Doctor Examination (MMI/IR)	\$150.00	\$0.00

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 §134.204 sets out the guidelines for billing and reimbursing Division-specific

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 309 – The charge for this procedure exceeds the fee schedule allowance.
 - P12 – Workers’ compensation jurisdictional fee schedule adjustment.
 - W3 – Additional payment made on appeal/reconsideration.
 - 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.
 - D1 – Duplicate Control Number ...

Issues

1. What is the Maximum Allowable Reimbursement (MAR) of the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. While the Medical Fee Dispute Resolution Request (DWC060) indicates that the dispute involves examinations for Maximum Medical Improvement (MMI), Impairment Rating (IR), Multiple Impairments, Extent of Injury, Return to Work, and a Work Status Report; the only examination with a balance in dispute is for MMI and IR. All other examinations are showing \$0.00 in dispute. Therefore, only the examinations for MMI and IR will be reviewed.

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 lumbar spine. No other impairment ratings were given. Therefore, the correct MAR for this examination is \$300.00.

2. The total MAR for the disputed services is \$650.00. The insurance carrier paid \$800.00. Therefore, no further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

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 \$0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	July 16, 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.