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
John Tuggle, D.C.

Respondent Name
Starr Indemnity and Liability Company

MFDR Tracking Number
M4-15-3298-01

Carrier's Austin Representative
Box Number 09

MFDR Date Received
June 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Gallagher Bassett on March 26, 2015. This request was in response to a $250.00 reducation of the $500.00 for the DDE performed on October 24, 2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… Tiered reimbursement is applicable to examinations performed under each single division order… Both bills have the same DWC #... Reduction was applied appropriately…"

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 24, 2014	Designated Doctor Examination (EOI)	$250.00	$250.00

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. 28 Texas Administrative Code §133.240 sets out the procedures for reimbursing or denying medical bills.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P1 – Not defined as required in 28 Texas Administrative Code §133.240
   - P12 – Workers' Compensation jurisdictional fee schedule adjustment.

- P300 – Not defined as required in 28 Texas Administrative Code §133.240.
- Z710 – Not defined as required in 28 Texas Administrative Code §133.240.

Issues

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

Findings

1. 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." The submitted documentation indicates that the Designated Doctor performed an examination to determine Extent of Injury.

   The insurance company argued in their position statement that the examination should be tiered because it is not the first designated doctor examination for this claim. However, 28 Texas Administrative Code §134.204 (i)(2) states, "When multiple examinations **under the same specific Division order** [emphasis added] 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 order for this examination included only the extent of injury examination that is disputed. Therefore, the correct MAR for this examination is $500.00.

2. The total MAR for the disputed services is $500.00. The insurance carrier paid $250.00. Therefore, an additional reimbursement of $250.00 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 $250.00.

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 $250.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	July 13, 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.