



# 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**

Benzel C. MacMaster, M.D.

**Respondent Name**

Arch Insurance Company

**MFDR Tracking Number**

M4-15-3347-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

June 9, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We billed carrier for a MMI/IR examination of which they paid MMI only...  
... there is an additional payment due of \$150.00 for the Impairment Rating using the DRE Method."

**Amount in Dispute:** \$150.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "It appears that the carrier is in the process of sending additional payment to the provider."

**Response Submitted by:** Flahive, Ogden & Latson

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 25, 2014	Treating Doctor Examination to Determine MMI/IR	\$150.00	\$143.98

### 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 §133.240 sets out the procedures for payment and denial of medical bills.
- 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division-specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 20 – (206) National Provider Identifier - missing
  - P1 – Not defined in accordance with 28 Texas Administrative Code §133.240. ASC X12 External Code Source 139 defines this code as "State-mandated Requirement for Property and Casualty."

## Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the Maximum Allowable Reimbursement for the disputed services?
3. Is the requestor entitled to additional reimbursement?

## Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 20 – "NATIONAL PROVIDER IDENTIFIER-MISSING." The insurance carrier did not maintain this denial on subsequent explanations of benefits. Therefore, this claim adjustment reason code will not be considered.

On reconsideration, the insurance carrier reduced disputed services with claim adjustment reason code P1,. The submitted documentation does not provide an explanation for this code. ASC X12 External Code Source 139 defines this code as "State-mandated Requirement for Property and Casualty." This code does not pertain to workers' compensation claims and will consequently not be considered. The insurance carrier's reduction reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §134.204 (j)(3) states, in relevant part,

The following applies for billing and reimbursement of an MMI evaluation.

(A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.

(i) Reimbursement shall be the applicable established patient office visit level associated with the examination.

(ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.

The dispute involves CPT code 99455-V4-WP. Therefore the applicable established patient office visit level associated with modifier V4 is 99214. The reimbursement for this office visit level is as follows:

For CPT code 99214 on November 25, 2014, the relative value (RVU) for work of 1.50 multiplied by the geographic practice cost index (GPCI) for work of 1.014 is 1.521000. The practice expense (PE) RVU of 1.41 multiplied by the PE GPCI of 1.013 is 1.428330. The malpractice (MP) RVU of 0.10 multiplied by the MP GPCI of 0.803 is 0.080300. The sum of 3.029630 is multiplied by the Division conversion factor for 2014 of \$55.75 for a MAR of \$168.90.

28 Texas Administrative Code §134.204 (j)(4) states,

The following applies for billing and reimbursement of an IR evaluation.

(A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form...

(C) ...

(ii) The MAR for musculoskeletal body areas shall be as follows.

(I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

Review of the submitted documentation finds that the requestor performed an evaluation to determine the impairment rating of the injured employee, using the DRE method. Therefore, the MAR for this examination is \$150.00.

3. The total MAR for the disputed services is \$318.90. The insurance carrier paid \$174.92. An additional reimbursement of \$143.98 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 \$143.98.

**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 \$143.98 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>October 9, 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.**