



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

Constance M. Moore, D.C.

Respondent Name

American Zurich Insurance Company

MFDR Tracking Number

M4-15-3727-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

July 13, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... the exam was performed as requested by on the DWC-32 by the carrier, through the Texas Department of Insurance, Division of Workers' Compensation."

Amount in Dispute: \$800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "842.04 is not a valid code"

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 3, 2015	Designated Doctor Examination (MMI/IR)	\$800.00	\$800.00

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 §133.10 sets out the requirements for completing medical bills.
- 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
- 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
- Texas Labor Code §408.0041 sets out the requirements relating to Designated Doctor Examinations.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 14 – (146) Diagnosis was invalid for the date(s) of service reported.
 - 193 – Not defined in accordance with 28 Texas Administrative Code §133.240

Issues

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

Findings

1. Texas Labor Code §408.0041 (h) states that "The insurance carrier shall pay for: (1) an examination required under Subsection (a), (f), or (f-2), unless otherwise prohibited by this subtitle or by an order or rule of the commissioner..." The insurance carrier denied disputed services with claim adjustment reason code "14 – (146) Diagnosis was invalid for the date(s) of service reported."

28 Texas Administrative Code §133.10 (f)(1)(M), which states that "at least one diagnosis code and the applicable ICD indicator must be present." A review of the submitted documentation finds that the requestor met this requirement. For this reason, the insurance carrier's denial 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. (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (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 upper extremities. The submitted documentation further indicates that the Designated Doctor performed an evaluation to determine the impairment rating of the spine using the DRE method found in the AMA Guides 4th edition. Therefore, the correct MAR for this examination is \$450.00.

The requestor included CPT Code 99456-W6-RE on the Medical Fee Dispute Resolution Request (DWC060), but indicated that \$0.00 were in dispute. Therefore, this code will not be addressed.

3. The total MAR for the disputed services is \$800.00. The insurance carrier paid \$0.00. Therefore, a reimbursement of \$800.00 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 \$800.00.

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 \$800.00 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

September 4, 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.