



# 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 Lecompte, D.O.

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-15-3847-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

July 24, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Per the Texas Fee Schedule when a person reaches MMI the charge that is allowed is \$350.00. Then for the IR the DRE Model was utilized so an additional charge of \$150.00 is allowed for a total allowable charge of \$500.00."

**Amount in Dispute:** \$150.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requestor billed \$500.00; Texas Mutual paid \$350.00. The requestor believes it is entitled to an additional \$150.00... The requestor billed \$300.00 for impairment rating of the ankle. However, there are no range of motion values of the ankle with the impairment rating. No additional payment is due."

**Response Submitted by:** Texas Mutual Insurance Company

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 16, 2015	Referral Doctor Examination for MMI/IR	\$150.00	\$150.00

### 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 §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - CAC-P12 – Workers' Compensation Jurisdictional fee schedule adjustment.

- 725 – Approved non network provider for Texas Star Network claimant per Rule 1305.153 (c).
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.

**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 (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 requestor performed an evaluation of Maximum Medical Improvement. 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.” The submitted documentation indicates that the requestor performed an evaluation to determine the impairment rating of the lower extremity using the DRE method found in the AMA Guides 4th edition. Therefore, the correct MAR for this examination is \$150.00.
2. The total MAR for the disputed services is \$500.00. The insurance carrier paid \$350.00. An additional reimbursement of \$150.00 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 \$150.00.

***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 \$150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

	Laurie Garnes	August 31, 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.**