



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

Linda Eberendu, D.C.

Respondent Name

Service Lloyds Insurance Company

MFDR Tracking Number

M4-15-4164-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

August 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This rule goes on to state when multiple IR's are required as a component of a DDE, the DD shall be reimbursed \$50 for each additional IR calculation."

Amount in Dispute: \$100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel maintains that payment in the amount of \$1,150.00 for designated doctor examination services on 03/30/15 addressing Maximum Medical Improvement, Impairment (MMI/IR) and Extent of Injury was made in accordance with workers' compensation specific services outlined under 28 TAC Chapter 134."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|--|-------------------|------------|
| March 30, 2015 | Designated Doctor Examination (Multiple Impairments) | \$100.00 | \$100.00 |

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 §133.10 sets out the requirements for a complete medical bill.
3. 28 Texas Administrative Code §133.210 sets out the procedures regarding medical documentation.
4. 28 Texas Administrative Code §127.10 sets out the procedures for Designated Doctor reports.
5. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 16 – Svc lacks info needed or has billing error(s)
 - 105 – Additional information needed to review charges

Issues

1. Was the medical bill completed in accordance with 28 Texas Administrative Code §133.10?
2. Did the insurance carrier request additional documentation in accordance with 28 Texas Administrative Code §133.210?
3. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 16 – “Svc lacks info needed or has billing error(s).” 28 Texas Administrative Code §133.10 sets out the requirements for a complete medical bill. Review of the submitted information finds that the billing meets the requirements of a complete medical bill in accordance with 28 Texas Administrative Code §133.10. The insurance carrier’s denial for this reason is not supported.
2. The insurance carrier denied disputed services with claim adjustment reason code 105 – “Additional information needed to review charges.” 28 Texas Administrative Code §133.210 (b) states, “When submitting a medical bill for reimbursement, the health care provider shall provide required documentation in legible form, unless the required documentation was previously provided to the insurance carrier or its agents.” Review of the submitted information finds that the required documentation for the designated doctor examination in question was included.

28 Texas Administrative Code §133.210 (d) further requires that,

Any request by the insurance carrier for additional documentation to process a medical bill shall:

- (1) be in writing;
- (2) be specific to the bill or the bill's related episode of care;
- (3) describe with specificity the clinical and other information to be included in the response;
- (4) be relevant and necessary for the resolution of the bill;
- (5) be for information that is contained in or in the process of being incorporated into the injured employee's medical or billing record maintained by the health care provider;
- (6) indicate the specific reason for which the insurance carrier is requesting the information; and
- (7) include a copy of the medical bill for which the insurance carrier is requesting the additional documentation.

Review of the submitted documentation does not support that the insurance carrier requested additional documentation in accordance with 28 Texas Administrative Code §133.210 (d). The insurance carrier’s denial for this reason is not supported. The disputed services will be reviewed in accordance with applicable rules and fee guidelines.

3. Per 28 Texas Administrative Code §127.10 (d),

...If a designated doctor is simultaneously requested to address MMI and/or impairment rating and the extent of the compensable injury in a single examination, the designated doctor **shall provide multiple certifications of MMI and impairment ratings that take into account each possible outcome for the extent of the injury**...If the designated doctor provided multiple certifications of MMI and impairment ratings, the designated doctor must file a Report of Medical Evaluation under §130.1(d) of this title for each impairment rating assigned and a Designated Doctor Examination Data Report pursuant to §127.220 of this title (relating to the Designated Doctor Reports) for the doctor’s extent of injury determination... [emphasis added]

Furthermore, 28 Texas Administrative Code §134.204 (j)(4)(B) states, “When multiple IRs are required as a component of a designated doctor examination ... the designated doctor shall bill for the number of body areas rated **and be reimbursed \$50 for each additional IR calculation**. Modifier ‘MI’ shall be added to the

MMI evaluation CPT code.” The submitted documentation indicates that the Designated Doctor was ordered to address Maximum Medical Improvement, Impairment Rating, and Extent of Injury. The narrative report and enclosed forms support that these examinations were performed and two additional certifications of impairment rating were provided. Therefore, the correct MAR for this service is \$100.00.

4. The total MAR for the disputed services is \$100.00. The insurance carrier paid \$0.00. An additional reimbursement of \$100.00 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 \$100.00.

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 \$100.00 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>September 28, 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.