



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

Joshua Linney, D.C.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-15-4185-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

August 26, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... the payment issued to us does not meet the recommended allowance as set by the Texas Medical Fee Guidelines for the procedures billed."

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester, as DESIGNATED DOCTOR, failed to complete the certification date in Box 18 as required by Rule 130.1(d). No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 15, 2015	Designated Doctor Examination	\$650.00	\$650.00

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 §130.1 defines the requirements for certification of maximum medical improvement and impairment rating.
- 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.

- CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
- 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.
- Notes: “892, 225 – BOX 10 IS BLANK. DWC-69 IS INCOMPLETE.”

Issues

1. Are the insurance carrier’s reasons for denial 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. The insurance carrier denied disputed services with claim adjustment reason codes CAC-16 – “CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION,” and 225 – “THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED...” The insurance carrier provided clarification on the reconsideration explanation of benefits, stating, “BOX 10 IS BLANK. DWC-69 IS INCOMPLETE.” In addition, the insurance carrier claimed that the requestor “failed to complete the certification date in Box 18 as required by Rule 130.1(d)” in their position statement.

28 Texas Administrative Code §130.1 defines the requirements for certification of maximum medical improvement and impairment rating. Review of the submitted information finds that the submitted documentation meets these requirements. 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 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. ... (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 requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the right knee. Therefore, the correct MAR for this examination is \$300.00.
3. The total MAR for the disputed services is \$650.00. The insurance carrier paid \$0.00. A reimbursement of \$650.00 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 \$650.00.

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 \$650.00 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 17, 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.