



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

Bonnie J. Lammers, M.D.

Respondent Name

Travelers Casualty and Surety Company

MFDR Tracking Number

M4-16-0657-01

Carrier's Austin Representative

Box Number 5

MFDR Date Received

November 12, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...I received yesterday a letter from Travelers which included a check for \$1450.00. They explain they would like to pay the \$650 for the 12/15/2014 DD evaluation BUT ONLY \$800 of the \$1,575.00 6/15/2015 DD evaluation...

Their payment is short \$775.00."

Amount in Dispute: \$775.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "With the reimbursement being issued, the Carrier contends the Provider is not entitled to additional reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: June 15, 2015, Designated Doctor Examination, \$775.00, \$0.00

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 §134.204 sets out the fee guidelines for division-specific services.
3. Texas Labor Code §408.0041 sets out the procedures for designated doctor examinations.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes: Submitted documentation does not find explanations of benefits included.

Issues

1. What is the dispute in question?
2. Is the requestor entitled to additional reimbursement?

Findings

1. While the Medical Fee Dispute Resolution Request (DWC060) includes a dispute for dates of service December 15, 2014 and June 15, 2015 with a total disputed amount of \$2225.00, the requestor has subsequently stated that they received partial payment. The requestor indicated that they received the full requested amount for date of service December 15, 2014 and \$800.00 for June 15, 2015. The requestor has indicated that the dispute includes the unpaid amount of \$775.00 for date of service June 15, 2015. This is the dispute that will be considered.
2. The submitted documentation does not find an explanation of benefits for the services in dispute. The services will therefore be reviewed in accordance with applicable statutes, rules, and fee guidelines.

Texas Labor Code §408.0041(h) states,

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...

Review of available information finds a division order for a designated doctor examination to resolve questions about the attainment of maximum medical improvement and the impairment caused by the compensable injury, in accordance with Texas Labor Code §408.0041(a)(1) and (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 maximum allowable (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 ankle. Therefore, the MAR for this examination is \$300.00.

The requestor is also seeking reimbursement of issues similar to those described in 28 Texas Administrative Code §134.204(i)(1)(A)-(E), with CPT code 99456-W9-RE. Review of the division order for the designated doctor exam does not find an order for questions in accordance with Texas Labor Code §408.0041(a)(6). Therefore, the requestor is not entitled to reimbursement of this service.

The requestor is also seeking reimbursement of the review of a specialist report with CPT code 99456-W5-SP. 28 Texas Administrative Code §134.204(j)(4)(D)(iii) states,

When the examining doctor refers testing for **non-musculoskeletal body area(s)** [emphasis added] to a specialist, then the following shall apply:

- (I) The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier "SP" and indicate one unit in the units column of the billing form. Reimbursement shall be \$50 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination.

Review of the submitted narrative does not find a referral for non-musculoskeletal body area(s) to a specialist. Therefore, the requestor is not entitled to reimbursement of this service.

The division finds that the requestor is entitled to a total reimbursement of \$650.00 for the disputed services. The insurance carrier paid \$800.00. Therefore, no further reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

	Laurie Garnes	December 17, 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.