



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

Jack P. Mitchell, D.C.

Respondent Name

Zenith Insurance Company

MFDR Tracking Number

M4-16-0722-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

November 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "For this exam, and as clearly indicated in the attached report, MMI was first determined then an impairment was calculated for one musculoskeletal body area, using a DRE evaluation for the cervical spine.

This provider should be reimbursed for first determining MMI for \$350.00, then Secondly for a DRE exam to spine for \$150.00."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Zenith Insurance maintains its position that this date of service was paid according to the fee guidelines at \$1,000.00."

Response Submitted by: The Zenith

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 6, 2015	Designated Doctor Examination	\$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 fee guidelines for division-specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 505 – MMI/IR certification denial due to blank or unverifiable provider license in header.
 - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

1. What are the services in dispute?
2. Is the insurance carrier's reason for denial of payment supported?
3. What is the maximum allowable reimbursement (MAR) for the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The Medical Fee Dispute Resolution Request (DWC060) indicates that the dispute involves procedure code 99456-WP-W5. The DWC060 lists the amount billed as \$1150.00. Review of the submitted documentation finds that this billed amount includes procedure codes 99456-WP-W5, billed at \$500.00; 99456-WP-W6, billed at \$500.00; and 99456-WP-MI, billed at \$150.00.

Per submitted Explanations of Benefits, the division finds that procedure codes 99456-WP-W6 and 99456-WP-MI were paid in full at the billed amount. Therefore, these procedure codes will not be considered for this dispute.

The division finds that procedure code 99456-WP-W5 was reimbursed at \$350.00, which is \$150.00 below the billed amount and is the amount in dispute on the DWC060. This is the procedure code that will be considered for this dispute.

2. The insurance carrier denied disputed services with claim adjustment reason code 505 – “MMI/IR CERTIFICATION DENIAL DUE TO BLANK OR UNVERIFIABLE PROVIDER LICENSE IN HEADER.” Review of the submitted information finds that the insurance carrier did not maintain this denial on reconsideration, nor was this issue discussed in the insurance carrier's position statement. For these reasons, the insurance carrier's denial for this reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
3. 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 spine using the DRE method found in the AMA Guides 4th edition. Therefore, the correct MAR for this examination is \$150.00.

4. The total MAR for the disputed service 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

_____	<u>Laurie Garnes</u>	<u>January 15, 2016</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.