



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

Orin Hall, M.D.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-16-0923-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

December 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...this request was in response to a \$150.00 reduction of the \$1565.00 for the Designated Doctor Exam performed on 07/18/2015."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided MMI?IR determinations as designated doctor and then billed Texas Mutual \$800.00 for 99456-W5/WP(2). Texas Mutual paid \$350.00 for the MMI exam and \$150.00 for the IR of the abdomen and \$150.00 for the groin, both non-musculoskeletal areas. The total paid \$650.00. 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
July 18, 2015	Designated Doctor Examination	\$150.00	\$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

- 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:
 - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
 - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

1. What are the disputed services in question?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. While the Medical Fee Dispute Resolution Request (DWC060) includes a work status form and examinations to determine the injured employee’s work status and if the injured employee’s disability was a result of the compensable injury, the requestor is seeking \$0.00 for these services. The requestor is seeking \$150.00 for the examination to determine if the injured employee had reached maximum medical improvement and the permanent impairment resulting from the compensable injury. These are the services that will be considered in this dispute.
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.

28 Texas Administrative Code §134.204(j)(4), which states that:

(D) ...

(i) Non-musculoskeletal body areas are defined as follows:

- (I) body systems;
- (II) body structures (including skin); and,
- (III) mental and behavioral disorders.

(ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides...

(v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.

Review of the submitted documentation finds that the requestor performed impairment rating evaluations of the abdomen and groin. 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 \$650.00. 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

Signature

Laurie Garnes

Medical Fee Dispute Resolution Officer

December 18, 2015

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.