



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

Clarence J. Wolinski, M.D.

Respondent Name

State Office of Risk Management

MFDR Tracking Number

M4-16-1588-01

Carrier's Austin Representative

Box Number 45

MFDR Date Received

February 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is the only MMI for this patient and hasn't been paid for in a previous payment as the EOB stated."

Amount in Dispute: \$300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Office reimbursed the treating doctor for his MMI evaluation on 1/28/2016 by way of direct deposit in the amount of \$109.51 ... for the billed V3 modifier which corresponds to the applicable office visit charge of 99213 pursuant to the aforementioned rule."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 13, 2015	Treating Doctor Evaluation of Maximum Medical Improvement	\$300.00	\$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 §134.203 sets out the fee guidelines for professional medical services.
- 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:
 - 247 – A payment or denial has already been recommended for this service.
 - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
 - 309 – The charge for this procedure exceeds the fee schedule allowance.

- P12 – Workers’ compensation jurisdictional fee schedule adjustment.

Issues

1. What is the maximum allowable reimbursement (MAR) for the disputed service?
2. Is the requestor entitled to additional reimbursement for the disputed service?

Findings

1. With respect to an examination to determine maximum medical improvement (MMI), 28 Texas Administrative Code §134.204(j)(3)(A) states,

An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.

- (i) Reimbursement shall be the applicable established patient office visit level associated with the examination.
- (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.

The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement and billed procedure code 99455 with modifier V3. Modifier V3 corresponds with the established patient office visit represented by procedure code 99213. Reimbursement for this code is determined in accordance with 28 Texas Administrative Code §134.203.

28 Texas Administrative Code §134.203(c) states,

To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

- (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83...
- (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year...

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2015 is \$56.20.

For procedure code 99213 on November 13, 2015, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 0.970000. The practice expense (PE) RVU of 1.01 multiplied by the PE GPCI of 0.920 is 0.929200. The malpractice (MP) RVU of 0.06 multiplied by the MP GPCI of 0.822 is 0.049320. The sum of 1.948520 is multiplied by the Division conversion factor of \$56.20 for a MAR of \$109.51.

Review of the submitted documentation does not support that the requestor performed an impairment rating for the injured employee.

2. The total MAR for the disputed service is \$109.51. Per the Explanation of Benefits dated January 12, 2016, the insurance carrier paid \$109.51. 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

_____	<u>Laurie Garnes</u>	<u>March 14, 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.