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
Scott Buchanan, D.C.

Respondent Name
Accident Fund Insurance Company of America

MFDR Tracking Number
M4-16-2198-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
March 29, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "When the carrier received the Medical Dispute, it requested it's audit company to reaudit the bill. As a result, and additional payment of $750.00 was allowed and payment issued on 4/12/2016."

Response Submitted by: Stone Loughlin & Swanson, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 11, 2015	Designated Doctor Examination	$100.00	$100.00

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. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 296 – Service exceeds maximum reimbursement guidelines.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.

Issues

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

Findings

1. In response to a subsequent reimbursement from the insurance carrier, the requestor submitted an amended Medical Fee Dispute Resolution Request (DWC060) indicating that they are seeking reimbursement of $100.00 for procedure code 99456-W5-MI with date of service November 11, 2015. Therefore, this is the only service considered for this dispute.
2. Per 28 Texas Administrative Code §127.10 (d),

   > …If a designated doctor is simultaneously requested to address MMI and/or impairment rating and the extent of the compensable injury in a single examination, the designated doctor shall provide multiple certifications of MMI and impairment ratings that take into account each possible outcome for the extent of the injury…If the designated doctor provided multiple certifications of MMI and impairment ratings, the designated doctor must file a Report of Medical Evaluation under §130.1 (d) of this title for each impairment rating assigned and a Designated Doctor Examination Data Report pursuant to §127.220 of this title (relating to the Designated Doctor Reports) for the doctor's extent of injury determination...

   Further, 28 Texas Administrative Code §134.204 (j)(4)(B) states,

   > When multiple IRs are required as a component of a designated doctor examination … the designated doctor shall bill for the number of body areas rated and **be reimbursed $50 for each additional IR calculation** [emphasis added]. Modifier 'MI' shall be added to the MMI evaluation CPT code.

   The submitted documentation indicates that the Designated Doctor was ordered to address Maximum Medical Improvement, Impairment Rating, and Extent of Injury. The narrative report and enclosed forms support that these examinations were performed, and 2 additional impairment ratings were provided. Therefore, the correct MAR for this service is $100.00.
3. The total MAR for the disputed service is $100.00. The insurance carrier paid $0.00. An additional reimbursement of $100.00 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 $100.00.

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 in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $100.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 12, 2016
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.