



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

Rollin Thrift, M.D.

Respondent Name

Hartford Underwriters Insurance Company

MFDR Tracking Number

M4-16-2203-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

March 29, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: \$315.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We received the original bill on May 21, 2015 ... and paid \$850.00 ... on June 4, 2015.

We advised at that time that 90801 was not listed CPT code in the state fee schedule.

We received a reconsideration on March 24, 2016 ... and paid and (sic) additional \$300.00 ... for CPT 99456-W5-WP...

We have paid a total of \$1,150.00 on this bill to date."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: May 12, 2015, Designated Doctor Examination, \$315.00, \$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 §133.20 sets out the procedures for submitting a medical bill.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 309 – The charge for this procedure exceeds the fee schedule allowance.
 - 561 – According to the state fee schedule this procedure code is not considered a valid reimbursable code. Please re-submit with a valid code.
 - 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed.
 - 115 – We find the original review to be accurate and are unable to recommend any additional allowance.

Issues

1. Is the insurance carrier's reason for denial of payment for procedure code 90801 supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The requestor is seeking reimbursement of \$15.00 for procedure code 90801. The insurance carrier denied this procedure with claim adjustment reason code 561 – "ACCORDING TO THE STATE FEE SCHEDULE, THIS PROCEDURE CODE IS NOT CONSIDERED A VALID REIMBURSABLE CODE. PLEASE RE-SUBMIT WITH A VALID CODE." 28 Texas Administrative Code §133.20(c) states that "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."

The division finds that procedure code 90801 was discontinued on January 1, 2013. The insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended for this service.

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 supports 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. ... (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area." The submitted documentation supports 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 shoulder. Therefore, the correct MAR for this examination is \$300.00.

Per 28 Texas Administrative Code §134.204(k),

The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

The submitted documentation indicates that the Designated Doctor performed an examination to determine the ability of the injured employee to return to work. Therefore, the correct MAR for this examination is \$500.00.

3. The total MAR for the disputed services is \$1150.00. The insurance carrier paid \$1150.00. 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 additional reimbursement for the services in dispute.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

April 20, 2016
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.