



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

Gilbert Mayorga, M.D.

Respondent Name

Granite State Insurance Company

MFDR Tracking Number

M4-16-3199-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 20, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In brief, the 99456 SP was for incorporation of the report required to determine whether or not the patient was at maximal medical improvement as well as the line item 99080 which was for the Form 73 required and answering the specific question of return to work Therefore, we respectfully request medical fee dispute resolution for the outstanding balance of \$65.00."

Amount in Dispute: \$65.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached find the explanation of bill review form showing that the carrier paid the proper amount for the MMI/IR exams and the return to work exams with no allowance for the reports. The carrier paid per the DWC Rule and asks that you find no additional monies are due the requestor."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: June 22, 2015, Designated Doctor Examination - Specialist Report Work Status Report, \$65.00, \$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 §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:
- For procedure code 99456-SP:
- 1 – Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
 - 2 – The number of units billed for this procedure code exceeds the reasonable number usually provided in a given setting, as defined within the Medically Unlikely Edits (MUEs) which is published and maintained by the Centers for Medicare and Medicaid Services. The provider’s charge was granted an allowance up to the MUE value.
- For procedure code 99080:
- 3 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 4 – The value of the procedure is included in the value of another procedure performed on this date.

Issues

1. Are the insurance carrier’s reasons for denial of payment for procedure code 99456-SP supported?
2. Are the insurance carrier’s reasons for denial of payment for procedure code 99080 supported?

Findings

1. The insurance carrier denied disputed procedure code 99456-SP stating, “Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.” 28 Texas Administrative Code §134.204(j)(4)(D)(iii)(I) provides that if billing for an Impairment Rating,
 - (iii) When the examining doctor refers testing for non-musculoskeletal body area(s) to a specialist, then the following shall apply:
 - (I) The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier "SP" and indicate one unit in the units column of the billing form. Reimbursement shall be \$50 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination.

Review of the submitted information does not support that the requestor provided or billed for the impairment rating of a non-musculoskeletal body area. The insurance carrier’s denial reason is supported. Additional reimbursement for this services cannot be recommended.
2. The insurance carrier denied disputed procedure code 99080 stating, “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated,” and “The value of the procedure is included in the value of another procedure performed on this date.” Per 28 Texas Administrative Code §134.204(l), “The following shall apply to Work Status Reports. When billing for a Work Status Report **that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section** [emphasis added], refer to §129.5 of this title (relating to Work Status Reports)”. Therefore, the filing of the DWC-073 is not separately payable when provided in conjunction with a Designated Doctor Examination performed according to 28 Texas Administrative Code §134.204(i). Additional reimbursement for this services cannot be 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

July 29, 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.