



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

Insurance Company of the State of Pennsylvania

MFDR Tracking Number

M4-16-3390-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

July 8, 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: \$450.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier will reimburse the proper amount and the requestor ..."

Response Submitted by: AIG

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 8, 2015	Designated Doctor Examination	\$450.00	\$450.00

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:
 - Please resubmit your bill with one or more of the following records that pertain to your bill: Operative report, discharge summary, itemized bill, anesthesia records, diagnostic reports, medical reports. Please attach a copy of this EOR with your resubmission. (W10)
 - Workers' compensation jurisdictional fee schedule adjustment.
 - The charge for the procedure exceeds the amount indicated in the fee schedule.

Issues

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

Findings

1. The requestor is seeking reimbursement for a designated doctor examination, including procedure codes 99456-W5-WP, 99456-W6-RE, 99456-W7-RE, 99456-W8-RE, and 99080-73. Subsequent to the receipt of the Medical Fee Dispute Resolution Request (DWC060), the insurance carrier paid the following procedure codes in full, per the Explanation of Bill Review dated August 9, 2016: 99456-W6-RE, 99456-W7-RE, 99456-W8-RE, and 99080-73. Therefore, these procedure codes will not be considered for this dispute.

With the same payment, the insurance carrier made a partial payment of procedure code 99456-W5-WP. The requestor stated, "Partial payment was received, they still have a balance of \$450.00." Therefore, this is the procedure and amount considered for this disputed.

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.

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

- (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
 - (i) Musculoskeletal body areas are defined as follows:
 - (I) spine and pelvis;
 - (II) upper extremities and hands; and,
 - (III) lower extremities (including feet).
 - (ii) The MAR for musculoskeletal body areas shall be as follows.
 - (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
 - (II) If full physical evaluation, with range of motion, is performed:
 - (-a-) \$300 for the first musculoskeletal body area; and
 - (-b-) \$150 for each additional musculoskeletal body area.
- (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 a right inguinal hernia and the lumbar spine, which included performance of a full physical evaluation with range of motion. Therefore, the correct MAR for this examination is \$450.00.

3. The total MAR for the services considered in this dispute is \$800.00. The insurance carrier paid \$350.00. An additional reimbursement of \$450.00 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 \$450.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 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 \$450.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____ Laurie Garnes _____	_____ August 31, 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.