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
Old Republic Insurance Company

MFDR Tracking Number
M4-18-0159-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
September 19, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… a designated doctor examination was performed on 10/20/2016 … we request that we be paid the disputed amount of $1500.00 which is according to the fee guideline…"

Amount in Dispute: $1,500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On October 3, 2017, upon review, Respondent determined that $850.00 was due to Requestor for the services at issue in this medical fee dispute … Respondent issued such payment to Requestor on October 6, 2017 (check number: 69504445) …

Respondent asserts that the correct fee schedule adjustment rate for procedure code 99456-W5-WP is $350.00, not $900.00 as Requestor claims. Furthermore, Respondent asserts that procedure code 99456 is either inconsistent with the Requestor's documented modifier "SP," or that Requestor failed to include the required modifier for that code, and therefore, the $50.00 Requestor billed for procedure code 99456-SP is incorrect …

Respondent asserts that $850.00 is the complete amount owed to Requestor for the services made subject of this medical fee dispute according to the Texas Workers' compensation Jurisdictional Fee Schedule."

Response Submitted by: Brown Sims

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 20, 2016	Designated Doctor Examination	$1,500.00	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.235 sets out the fee guidelines for return to work/evaluation of medical care examinations performed on or after September 1, 2016.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating performed on or after September 1, 2016.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 304 – MMI or IR certification is not valid for this date of service.
   - 375 – Please see special *note* below.
   - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - B12
   - 306 – To reprice this code requires the appropriate modifier. Please attach the appropriate modifier and resubmit.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guidelines.

Issues

1. Did Old Republic Insurance Company (Old Republic) maintain its denial based on certification/eligibility?
2. Is Gilbert Mayorga, M.D. entitled to additional reimbursement?

Findings

1. Dr. Mayorga is seeking reimbursement of $1,500.00 for a designated doctor examination performed on October 10, 2016. Per Explanation of Benefits dated December 6, 2016, Old Republic denied payment, in part, with claim adjustment reason codes 304 – "MMI OR IR CERTIFICATION IS NOT VALID FOR THIS DATE OF SERVICE," and B7 – "THIS PROVIDER WAS NOT CERTIFIED/ELIGIBLE TO BE PAID FOR THIS PROCEDURE/SERVICE ON THIS DATE OF SERVICE."

   Review of the submitted documentation finds that Old Republic did not maintain this denial on subsequent explanations of benefits, paying the billed services in part.

2. 28 Texas Administrative Code §134.250 (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 an abdominal strain, an inguinal strain, and a hip strain, including range of motion. The maximum allowable reimbursement (MAR) for this examination is $600.00.

Per 28 Texas Administrative Code §134.235,

> 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 extent of the compensable injury. Therefore, the correct MAR for this examination is $500.00.

28 Texas Administrative Code §134.250 (4)(D) provides that if billing for an Impairment Rating,

> (iii) When the examining doctor refers testing for **non-musculoskeletal body area(s)** [emphasis added] 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 referred testing for a **non-musculoskeletal body area** to a specialist. Reimbursement for this service cannot be recommended.

The reimbursement for the disputed services is calculated as follows:

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]		$350.00
IR: Left Hip Strain	Musculoskeletal System	Lower Extremities	$300.00
IR: Abdominal Strain	Digestive System	Body Systems	$150.00
IR: Inguinal Strain			
Total MMI	[redacted]		**$350.00**
Total IR			**$450.00**
Total Extent of Injury			**$500.00**
Total Special Report			**$0.00**
Total Exam			**$1,300.00**

The total reimbursement for the disputed services is $1,300.00. Per Explanations of Benefits presented to the division, Old Republic paid $850.00. An additional reimbursement of $450.00 is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. 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 Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $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	February 1, 2018
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 Rule §133.307, effective May 31, 2012, *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. **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.