



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

Terence Floyd, D.C.

Respondent Name

Selective Insurance Company of America

MFDR Tracking Number

M4-18-0976-01

Carrier's Representative

Box 22

MFDR Date Received

December 7, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr Certification Is and Was Valid At Time of Exam"

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: A copy of the dispute was provided to Broadspire via e-mail on behalf of Selective Insurance Company of America. Submitted documentation does not include a position statement from the respondent.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: August 21, 2017, Designated Doctor Examination, \$650.00, \$650.00

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 §127.100 sets out the requirements for certification of designated doctors.
3. 28 Texas Administrative Code §130.1 defines the requirements for certification of maximum medical improvement and impairment rating.
4. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating on or after September 1, 2016.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment

codes:

- B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.
- 304 – MMI or IR certification is not valid for this date of service.

Issues

1. Did Selective Insurance Company of America (Selective) respond to the medical fee dispute?
2. Is Selective’s reason for denial of payment supported?
3. Is Terence Floyd, D.C. entitled to reimbursement for the disputed services?

Findings

1. The division provided a copy of the dispute to Broadspire, an agent of Selective, on December 14, 2017. Review of the submitted documentation finds that no response has been received from Selective to date. The division concludes that Selective failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.
2. Dr. Floyd is seeking reimbursement of \$650.00 for a designated doctor examination to determine maximum medical improvement and impairment rating, as requested by Broadspire and ordered by the division.

Selective denied the disputed services, in part, with claim adjustment reason code 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 Dr. Floyd was certified as a designated doctor and certified to perform examinations to determine maximum medical improvement and impairment ratings as required by 28 Texas Administrative Codes §§127.100 and 130.1. Selective’s denial for this reason is not supported.

Selective also denied the disputed services, in part, with claim adjustment reason code 304 – “MMI OR IR CERTIFICATION IS NOT VALID FOR THIS DATE OF SERVICE.” Documentation submitted to the division does not support that the certification of maximum medical improvement and impairment rating was invalid on the date of service. Selective’s denial for this reason is not supported.

3. Per 28 Texas Administrative Code §134.250 (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 Dr. Floyd performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is \$350.00.

Per 28 Texas Administrative Code §134.250 (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 Dr. Floyd provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the cervical and lumbar spine. Therefore, the MAR for this examination is \$300.00.

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 \$650.00.

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 \$650.00, 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 9, 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.