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
Travelers Indemnity Company of Connecticut

MFDR Tracking Number
M4-19-1595-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
November 19, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "To date we have received an additional payment from the carrier, and they have now paid a total amount of line item 99456 $950. However, the fourth and final body area that was impaired as per my report has not been paid. Therefore, an outstanding balance of $150.00."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier reviewed and processed the billing, issuing reimbursement in total of $950.00 … The Provider has been appropriately reimbursed for the disputed services in accordance with the Division-adopted fee schedule, and no additional reimbursement is due."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 5, 2017	Designated Doctor Examination	$150.00	$150.00

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 §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 181 – Payment adjusted because this procedure code was invalid on the date of service.

- 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.
- 600 – Allowance based on maximum number of units allowed per fee schedule guidelines and/or service code description.
- 254 – The billed service has no allowance in fee schedule/UCR.
- W3 – Additional payment made on appeal/reconsideration.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Dr. Mayorga is seeking an additional $150.00 for a designated doctor examination to determine maximum medical improvement and impairment rating performed on December 5, 2017.

The designated doctor is required to bill an examination to determine maximum medical improvement with CPT code 99456 and modifier "W5."[1] Reimbursement is $350.00 for this examination.[2] The submitted documentation supports that Dr. Mayorga performed an evaluation of maximum medical improvement as ordered by the division. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

Review of the submitted documentation finds that Dr. Mayorga performed impairment rating evaluations of a upper extremity, lower extremity, the spine, and a head contusion. The MAR for the evaluation of the upper extremity, a musculoskeletal body area performed with range of motion is $300.00.[3] The MAR for the evaluations of subsequent musculoskeletal body areas, a lower extremity and spine, is $150.00 per body area.[4] The MAR for the evaluation of a head contusion, a non-musculoskeletal body area, is $150.00.[5] The total MAR for the determination of impairment rating is $600.00.

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]		$350.00
IR: Left Shoulder (ROM)	Musculoskeletal System	Upper Extremities	$300.00
IR: Right Hip (ROM)	Musculoskeletal System	Lower Extremities	$150.00
IR: Right Knee (ROM)			
IR: Left Ankle/Foot (ROM)			
IR: Cervical Spine (DRE)	Musculoskeletal System	Spine	$150.00
IR: Thoracolumbar Spine			
IR: Lumbosacral Spine (DRE)			
IR: Head Contusion	Skin	Body Structures	$150.00
Total MMI	[redacted]		**$350.00**
Total IR			**$750.00**
Total Exam			**$1,100.00**

The total allowable reimbursement for the disputed examination is $1,100.00. The insurance carrier reimbursed $950.00. An additional reimbursement of $150.00 is recommended.

[1] 28 Texas Administrative Codes §§134.250(3)(C) and 134.240(1)(B)
[2] 28 Texas Administrative Code §134.250(3)(C)
[3] 28 Texas Administrative Code §134.250(4)(C)(ii)(II)(-a-)
[4] 28 Texas Administrative Code §134.250(4)(C)(ii)(II)(-b-)
[5] 28 Texas Administrative Code §134.250(4)(D)(v)

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 $150.00.

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 $150.00, 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 8, 2019
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.