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
Enas Pruitt, M.D.

Respondent Name
Bitco National Insurance Company

MFDR Tracking Number
M4-19-4242-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 28, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "POST DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED"

Amount in Dispute: $850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier agrees that the provider is entitled to reimbursement … the provider has used modifiers that apply to a designated doctor exam … Once that modifier issue is resolved, the carrier will issue payment pursuant to the Medical Fee Guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 8, 2019	Examination to Determine Maximum Medical Improvement and Impairment Rating	$800.00	$800.00
January 8, 2019	Multiple Impairment Calculations	$50.00	$0.00
	Total	$850.00	$800.00

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 (DWC).

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:
   - 242 – Services not provided by network/primary care prov

- Notes: “Per rule 134.210(e) – This modifier shall be added to CPT code 99456 when the designated doctor is required to complete multiple impairment ratings calculations. This is not a DD exam”
- Notes: “Out-of-network approval not requested prior to rendering services”
- Notes: “Per the Labor Code: 401.011(19) ‘Health care’ includes all reasonable and necessary medical aid, MEDICAL EXAMINATIONS, medical treatments, medical diagnoses, MEDICAL EVALUATIONS, and medical services.”
- Notes: “As this is a medical exam to determine MMI/IR and the IW is in the HCN, the TD is required to refer to an IN NETWORK PROVIDER.”
- 234 – This procedure is not paid separately.

Issues

1. Did the insurance carrier maintain its denial of payment for the services in question based on network status?
2. Are the insurance carrier’s denials of payment supported?
3. Is Dr. Pruitt entitled to additional reimbursement?

Findings

1. Dr. Pruitt is seeking reimbursement for an examination to determine maximum medical improvement (MMI) and impairment rating (IR) with multiple impairment calculations. In its position statement, Flahive, Ogden & Latson stated on behalf of the insurance carrier that “the carrier agrees that the provider is entitled to reimbursement. However, the provider has used modifiers that apply to a designated doctor exam.”

   The DWC concludes that the insurance carrier did not maintain its denial of payment for the services in question based on network status.

2. Per explanations of benefits submitted with the request for medical fee dispute resolution, billing code 99456-MI was denied, in part stating, “This modifier shall be added to CPT code 99456 when the designated doctor is required to complete multiple impairment ratings calculations. This is not a DD exam.”

   The only instance that applies to billing code 99456 with modifier “MI” is a designated doctor examination that includes MMI, IR, and extent of injury.[1] The DWC finds that the examination in question is not a designated doctor examination. The insurance carrier’s denial of this billing code for this reason is supported.

3. The DWC finds that Dr. Pruitt is entitled to reimbursement for the examination to determine MMI and IR.

   The submitted documentation supports that Dr. Pruitt performed an evaluation of maximum medical improvement. The maximum allowable reimbursement (MAR) for this examination is $350.00.[2]

   Review of the submitted documentation finds that Dr. Pruitt performed impairment rating evaluations of the spine and head. The MAR for the evaluation of the spine, a musculoskeletal body area, performed with range of motion is $300.00.[3] The MAR for the evaluation of the head, a non-musculoskeletal body area, is $150.00.[4] The total MAR for the determination of impairment rating is $450.00.

   The total allowable for the examination in question is $800.00. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $800.00.

[1] 28 TAC §134.250(4)(B)
[2] 28 TAC §134.250(3)(C)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[4] 28 TAC §134.250(4)(D)(v)

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $800.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

____________________________	Laurie Garnes	October 11, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.