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
Benjamin Burris, M.D.

Respondent Name
Federal Insurance Company

MFDR Tracking Number
M4-19-4564-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
June 20, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "POST DESIGNATED DOCTOR EXAM INCORRECT REDUCTION"

Amount in Dispute: $250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel determined reimbursement for CPT code 99456 (-WP) was erroneously reimbursed. Therefore, additional reimbursement of $150.00 is, warranted … CorVel will maintain denial for CPT code 99456 (-MI) in dispute based on rule 134.210(e)(5) MI, multiple impairment ratings—this modifier shall be added to CPT code 99455 when the designated doctor is required to complete multiple impairment ratings calculations. The billing in question is for a Post DD RME and not designated doctor services."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 17, 2019	Post-Designated Doctor Examination	$250.00	$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 citing workers' compensation fee guidelines.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Dr. Burris is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating (IR) with multiple determinations of impairment.

The insurance carrier's position statement indicates that it did not maintain its reduction of reimbursement for CPT code 99456-WP, stating that "additional reimbursement of $150.00 is, warranted." No explanation of benefits was provided to support that this payment was reimbursed to Dr. Burris. Therefore, the DWC concludes that Dr. Burrus is entitled to and additional $150.00 for this service.

The insurance carrier maintained its denial of CPT code 99456-MI. When multiple IRs are required as a component of a **designated doctor** examination, the **designated doctor** is to bill and be reimbursed for each additional IR calculation.[1] The evidence submitted to the DWC does not support that Dr. Burris was acting as a designated doctor, but rather a doctor selected by the treating doctor acting in place of the treating doctor. Therefore, no reimbursement is recommended for this service.

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 $150.00.

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 $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	September 10, 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.

[1] 28 TAC §134.250(4)(B)