



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

Phuc Armstrong, D.C.

Respondent Name

Service Lloyds Insurance Company

MFDR Tracking Number

M4-19-5089-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

August 2, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION ... The rule indicates 'if a full physical evaluation WITH RANGE OF MOTION IS PERFORMED the MAR shall be \$300.00 for the first musculoskeletal body area and \$150.00 for each additional musculoskeletal body area.'"

Amount in Dispute: \$250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are recommending additional \$50 for 99456-W5-MI, because Multiple Impairment Ratings by Designated Doctor When multiple IRs are required as a component of a designated doctor examination ... We do find that one Report has DX S39.012A written at the top 'Compensable Injury' and second report DX S39.012A & S33.5XXA indicating 'Compensable with included disputed' ... However, we are upholding the original review allowance for 99456-W5-WP. No additional allowance Impairment rating was given using DRE method as indicated on the documentation submitted with reconsideration bill ... There is only one body area and thus DRE -\$150 ..."

Response Submitted by: AViDEL

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Rows include various designated doctor examinations and a work status report, totaling \$250.00 in dispute and \$150.00 due.

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:
 - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
 - P12 – Workers' compensation jurisdictional fee schedule adjustment.
 - Notes: "DOCUMENTATION SUPPORTS MMI FOR ONE BODY ARE: LUMBAR SPINE 5% IMPAIRMENT RATING BY DRE
 - Notes: "MULTIPLE IMPAIRMENT RATINGS ARE REIMBURSED PER ADDITIONAL BODY AREA"
 - 375 – Please see special *Note* below
 - Notes: "NO ADDITIONAL ALLOWANCE IMPAIRMENT RATING WAS GIVEN USING DRE METHOD AS DOCUMENTED ON PG 32 OF DOCUMENTATION."
 - Notes: "MULTIPLE IMPAIRMENT RATINGS ARE REIMBURSED PER ADDITIONAL BODY AREA, THERE IS ONLY ONE IMPAIRMENT RATING GIVEN THUS THERE ARE NOT MULTIPLE IMPAIRMENTS"
 - 188 – Payment of interest/penalty to provider.
 - 225 – Penalty or interest payment by payer.
 - Notes: "We are recommending additional \$50 for 99456-W5-MI, because Multiple Impairment Ratings by Designated Doctor When multiple IRs are required as a component of a designated doctor examination [see Rule 130.6], the following guidelines apply: *The designated doctor bills for the number of body areas rated 31 *Reimbursement is \$50 for each additional IR calculation * Add the 'MI' modifier to the MMI evaluation CPT code. We do find that one Report has DX S39.012A written at the top 'Compensable Injury' and second report DX S39.012A & S35.5XXA indicating 'Compensable with included disputed'. However, we are upholding the original review allowance for 99456-W5-WP. No additional Impairment rating was given using DRE method as indicated on the documentation submitted with reconsideration bill ... page 32. There is only one body area and thus DRE - \$150 / \$150 each additional area thus Plus \$350 for MMI/IR total allowance was accurately at MAR \$500."

Issues

1. What are the services considered in this dispute?
2. Is Dr. Armstrong entitled to additional reimbursement for the examination in question?

Findings

1. Dr. Armstrong is seeking \$0.00 for procedure codes 99456-W6-RE, 99456-W7-RE, 99456-W8-RE. Therefore, these services will not be considered in this dispute.

Dr. Armstrong is seeking \$150.00 for procedure code 99456-W5-WP and \$100.00 for procedure code 99456-W5-MI. These services will be reviewed in this dispute.

The submitted documentation supports that Dr. Armstrong performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is \$350.00.¹ The submitted documentation supports that Dr. Armstrong provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the lumbar spine. Reimbursement is \$300.00 for the first musculoskeletal body area if a full physical evaluation

¹ 28 TAC §134.250(3)(C)

with range of motion is performed.² Service Lloyds Insurance Company reimbursed \$500.00 for these services. An additional \$150.00 is recommended.

The submitted documentation indicates that Dr. Armstrong was ordered to address maximum medical improvement, impairment rating, and extent of injury. The narrative report and enclosed forms support that these evaluations were performed, and 1 additional impairment rating was provided. Therefore, the correct MAR for this service is \$50.00.³ Per explanation of benefits dated August 20, 2019, Service Lloyds Insurance Company reimbursed this amount in full. No further reimbursement is recommended for this service.

The total allowed reimbursement is \$150.00. 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 \$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

_____	<u>Laurie Garnes</u>	<u>November 8, 2019</u>
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.

² 28 TAC §134.250(4)(C)(ii)(II)(-a-)

³ 28 TAC §134.250(4)(B)