TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Casa View Chiropractic Clinic, Inc.

**Respondent Name**
Safety National Casualty Corp.

**MFDR Tracking Number**
M4-19-5258-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
August 23, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The insurance company sent a payment of $650 and the schedule fee amount for this exam is $800."

**Amount in Dispute:** $150.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "CorVel maintains, the requestor Casa View Chiropractic Clinic is entitled to **$0.00** additional reimbursement for the medical disability examination performed on 06/24/19 to address Impairment (MMI/IR) based on failure to appropriately submit medical billing in accordance with workers' compensation specific services outlined under 28 TAC Chapter 134."

**Response Submitted by:** CorVel

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| June 24, 2019 | Designated Doctor Examination | $150.00 | $0.00 |

## *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:
   - ORC – See Additional Information
   - Notes: "MMI / IR +(ROM) 1 area

- P12 – Workers' compensation state fee schedule adjustment
- 18 – Duplicate claim/service
- R1 – Duplicate billing

**Issues**

Is the requestor entitled to additional reimbursement?

**Findings**

Casa View Chiropractic Clinic, Inc. is seeking additional reimbursement for a designated doctor examination performed on June 24, 2019.

A designated doctor has a duty to bill using CPT code 99456 with the number of body areas indicated in the "UNITS" column of the CMS1500 form.

The DWC finds that Casa View Chiropractic Clinic, Inc. indicated 1 unit on its billing form. The maximum allowable reimbursement for an examination to determine maximum medical improvement is $350.00.[1] Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[2]

The total allowable for the disputed service is $650.00. The insurance carrier paid this amount. No additional reimbursement is recommended.

**Conclusion**

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *ORDER*

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

**Authorized Signature**

| | Laurie Garnes | September 18, 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(3)(C)
[2] 28 TAC §134.250(4)(C)(ii)(II)(-a-)