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
MED-LOSS INC

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-20-0237-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… to date we have not received payment from the carrier."

Amount in Dispute: $1,665.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We are attaching the carrier's EORs, including one dated December 20, 2018 that recommended reimbursement of $1,600.00 … it is the carrier's position that the provider was already reimbursed $1,100.00 for the MMI and impairment rating portion of the exam as well as $500.00 for the ability to return to work portion of the exam.

The provider is seeking additional reimbursement of $50.00 for a report and $15.00 for a DWC-75 work status report. However, those documents are documents that are expected to be prepared based upon the MMI/Impairment rating and ability to return to work exams. They are included within the reimbursement amounts for the MMI, impairment rating and ability to return to work exams."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2018	Designated Doctor Examination (99456-W5-WP)	$1,100.00	$0.00
October 25, 2018	Designated Doctor Examination (99456-W7-RE)	$500.00	$0.00
October 25, 2018	Specialist Report (99456-SP)	$50.00	$50.00
October 25, 2018	Work Status Form (99080)	$15.00	$0.00
	Total	$1,665.00	$50.00

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 §134.239 sets out the guidelines for Work Status Forms filed with a designated doctor examination.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 600 – Allowance based on maximum number of units allowed per fee schedule guidelines and/or service code description.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.
   - W3 – Additional payment made on appeal/reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. What services are evaluated in this dispute?
2. Is Med-Loss, Inc. entitled to additional reimbursement for the services in dispute?

Findings

1. Med-Loss, Inc. is seeking additional reimbursement for services associated with a designated doctor examination. Per Explanation of Bill Review dated December 20, 2018, the insurance carrier reimbursed procedure codes 99456-W5-WP and 99456-W7-RE in full. The DWC will not consider these services in this dispute.

   The insurance carrier denied payment for procedure codes 99456-SP and 99080 citing the fee guidelines. The DWC will review these services in this dispute.

2. When the designated doctor refers an injured employee to a specialist for testing of a non-musculoskeletal body area and incorporates that report into the impairment rating, the designated doctor bills procedure code 99456-SP. Reimbursement is $50.00 for this service.[1]

   The records submitted to the DWC show that Dr. Gilbert Mayorga referred the injured employee to Dr. Bob Gant for a neuropsychological examination and used Dr. Gant's report for the impairment rating of the head contusion. Med-Loss, Inc. is entitled to $50.00 for this service.

   A work status report is not payable when it is required for a designated doctor report.[2] Med-Loss, Inc. is not entitled to reimbursement for this service.

   The total allowable reimbursement for the services in question is $50.00. This amount is recommended.

[1] 28 TAC §134.250 (4) (D) (iii)
[2] 28 TAC §134.239

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 $50.00.

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 $50.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	December 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.