TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
PACIFIC BILLING

Respondent Name
Berkley Casualty Company

MFDR Tracking Number
M4-20-0643-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 8, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 25, 2019	Designated Doctor Examination	$800.00	$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:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 973 – Payment denied as this modifier is incorrect or no longer valid.

Issues

1. Did Berkley Casualty Company respond to the medical fee dispute?
2. Is Pacific Billing entitled to additional reimbursement for the service in question?

Findings

1. The Austin insurance carrier representative for Berkley Casualty Company is Flahive, Ogden & Latson. The representative received the copy of this medical fee dispute on November 19, 2019. If the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.[1]

   As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. Pacific Billing is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating, billed with procedure code 99456-W5-WP.

   Per explanations of benefits dated September 4, 2019, and September 24, 2019, the insurance carrier reviewed and denied procedure code 99455-W5-WP. No evidence was presented to support that this code was billed. No evidence was submitted to support that the insurance carrier reviewed the billed code 99456-W5-WP.

   A designated doctor is required to bill an examination to determine maximum medical improvement with procedure code 99456 and modifier "W5."[2] The DWC finds that Pacific Billing correctly submitted a bill for the examination in question and is entitled to reimbursement.

   The submitted documentation supports that Kasey Kunkel, D.C. performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[3]

   Review of the submitted documentation finds that Dr. Kunkel performed impairment rating evaluations, including range of motion, of the upper and lower extremities. The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[4] The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00.[5] The total MAR for the determination of impairment rating for this examination is $450.00.

   The total allowable reimbursement for the disputed examination 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.

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.

[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §§134.250(3)(C) and 134.240(1)(B)
[3] 28 TAC §134.250(3)(C)
[4] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[5] 28 TAC §134.250(4)(C)(ii)(II)(-b-)

Authorized Signature

	Laurie Garnes	January 6, 2020
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 division 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.