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
ENDSLEY, FERRAL L

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-20-1492-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 14, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We were only paid for an office visit even though the HCFA clearly states this was for an impairment rating."

Amount in Dispute: $150.00

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
November 12, 2019	Examination to Determine Maximum Medical Improvement and Impairment Rating	$150.00	$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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional services.
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:
   - D0223 – (P12) Workers' compensation jurisdictional fee schedule adjustment.
   - 00663 – Reimbursement has been calculated according to state fee schedule guidelines.
   - Z710 – The charge for this procedure exceeds the fee schedule allowance.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did New Hampshire Insurance Company respond to the medical fee dispute?
2. Is Ferral Endsley, D.O. entitled to additional reimbursement?

Findings

1. The Austin insurance carrier representative for New Hampshire Insurance Company is Flahive, Ogden & Latson. The representative received the copy of this medical fee dispute on March 3, 2020. 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. Dr. Endsley is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating performed as a treating doctor on November 12, 2019. Dr. Endsley billed the examination with procedure code 99455-V3-WP.

   The treating doctor is required to bill an examination to determine maximum medical improvement and impairment rating using procedure code 99455.[2] The doctor is also required to use modifiers "V1" through "V5" to correspond with the last digit of the applicable established patient office visit.[3] If the examining doctor performs the IR testing of a musculoskeletal body area, the doctor is required to use modifier "WP."[4]

   The examination to determine maximum medical improvement for this dispute is calculated based on the applicable established office visit, as noted above. In this case, the applicable established patient office visit is represented by 99213.

   Reimbursement for procedure code 99213 is based on Medicare policies using the conversion factor determined by the division for the appropriate year.[5] The conversion factor for 2019 is $59.19.[6] Therefore, the maximum allowable reimbursement is $119.01.

   Dr. Endsley also provided impairment ratings for the spine. The MAR for the evaluation of a musculoskeletal body area determined using the DRE method is $150.00.[7]

   The total allowable for the examination in question is $269.01. The insurance carrier paid $119.01. An additional payment of $150.00 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.

[1] 28 TAC §133.307 (d)(1)
[2] 28 TAC §134.250 (3)(A) and (B)(ii)
[3] 28 TAC §134.250 (3)(A)(ii)
[4] 28 TAC §134.250 (4)(C)(iii)
[5] 28 TAC §134.203(b) and (c)
[6] https://www.tdi.texas.gov/bulletins/2018/documents/001718table.pdf#CY2019 Table of Conversion Factors
[7] 28 TAC §134.250(4)(C)(ii)(I)

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

		May 27, 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 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.