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
DOBSON, ALEXIS MARIE

Respondent Name
ACIG INSURANCE CO

MFDR Tracking Number
M4-20-2201-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 5, 2020

REQUESTOR'S POSITION SUMMARY

"AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: $582.62

RESPONDENT'S POSITION SUMMARY

"In light of the additional file material that was included in Dr. Dobson's MDR request, ACIG has processed payment for the dispute amount."

Response Submitted by: Burns Anderson Jury & Brenner, L.L.P.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 11, 2019	Designated Doctor Examination: 99456-W6-RE	$500.00	$500.00
November 11, 2019	Range of Motion Testing x 3	$82.62	$82.62
	Test	$582.62	$582.62

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 medical services.
3. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine the extent of a compensable injury.
4. The submitted documentation did not include explanations of benefits.

Issues

1. Did ACIG Insurance Company take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
2. Is Alexis Dobson, D.C. entitled to reimbursement for the examination in question?

Findings

1. Dr. Dobson is seeking reimbursement for a designated doctor examination to determine the extent of the compensable injury and range of motion testing. Dr. Dobson argued that it had not received payment or an explanation of denial for medical bills submitted for the examination in question.

   The insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information.[1]

   The greater weight of evidence presented to the DWC supports that a complete bill for the services in question was received by the insurance carrier or its agent. No evidence was provided to support that the insurance carrier took final action on the bill for the service in question.

2. Burns Anderson Jury & Brenner, L.L.P. stated that payment was processed after the request for medical fee dispute resolution. No evidence was provided for this payment. Dr. Dobson's agent stated via email dated July 8, 2020, that no payment was received. The greater weight of evidence presented indicates that Dr. Dobson was not reimbursed for the services in question and is therefore entitled to reimbursement.

   The submitted documentation indicates that Dr. Dobson performed an examination to determine the extent of the compensable injury. The MAR for this examination is $500.00.[2]

   An examination by a designated doctor to determine the extent of a compensable injury, represented by CPT code 99456 with modifiers "W6" and "RE," is a division-specific service not subject to Medicare billing rules. If the doctor determines that additional testing is required to make a determination, the testing "shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."[3]

   Documentation submitted to the DWC supports that Dr. Dobson performed range of motion testing for the lumbar spine and both knees. Range of motion testing, represented by CPT code 95851, was billed at one unit for each extremity and the spine. Therefore, Dr. Dobson is entitled to reimbursement of these services at three units.

   Reimbursement for the services in question are based on Medicare policies using the conversion factor determined by the DWC for the appropriate year.[4] The conversion factor for 2019 is $59.19.[5] Therefore, the maximum allowable reimbursement is $103.47. Dr. Dobson is seeking $82.62. This amount is recommended.

   The total allowable reimbursement for the examination in question is $582.62. 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 $582.62.

[1] 28 TAC §133.240 (a)
[2] 28 TAC §134.235
[3] 28 TAC §134.235
[4] 28 TAC §134.203(b) and (c)
[5] https://www.tdi.texas.gov/wc/fee/conversionfactors.html#conv

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 $582.62, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July 24, 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.