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
RUSHING, DEAN HOLDEN

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-20-2598-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
June 30, 2020

REQUESTOR'S POSITION SUMMARY

"99456 W5 WP MMI = $350.00
IR – W/ROM = $300.00
TTL = $650.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Indemnity Insurance Company of North America is Downs & Stanford, P.C. The representative was notified of this medical fee dispute on July 7, 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.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 7, 2019	Designated Doctor Examination (99456-W5-WP)	$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 §134.250 sets out the fee guidelines for examinations to determine maximum

[1] 28 TAC §133.307(d)(1)

medical improvement and impairment rating.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 6766 – Specialty Bill Audit/Exper Code Review involving the application of code auditing rules and edits based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, and coding guidelines dev
   - 119 – Benefit maximum for this time period or occurrence has been reached.
   - 186 – Additional charges received, but no additional allowance is recommended due to the maximum allowance for this admission has been reached.
   - 285 – Please refer to the note above for a detailed explanation of the reduction.
   - Notes: "Per 28 TAC 134.210 (e) (5), modifier MI can only be applied to CPT 99455. It is not applied to 99456."
   - 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.
   - 6863 – Equian previously paid this amount.

Issues

Is Dean Rushing, D.C. entitled to additional reimbursement for the examination in question?

Findings

Dr. Rushing is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating.

The submitted documentation supports that Dr. Rushing performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[2]

The submitted documentation supports that Dr. Rushing provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the spine. The MAR is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[3]

The total MAR for the disputed examination is $650.00. The insurance carrier paid $500.00. An additional reimbursement 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.

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

		August 25, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

[2] 28 TAC §134.250(3)(C)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-a-)

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.