



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

Justin Perish, D.C.

Respondent Name

Zenith Insurance Company

MFDR Tracking Number

M4-17-3467-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

July 26, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = 350.00
IR w/ ROM = 300.00
Total Paid = 350.00
Balance Due = 300.00"

Amount in Dispute: \$100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Zenith's position is that no additional payment is due to the provider.

- 99456-W5-MI (line 1): No payment should have been processed as there are not multiple body parts, only the knee. **This payment is being applied to line 3 (99456-W5-WP).**
- 99456-W5-WP (line 3): Fee schedule is \$350.00 plus the \$300.00 for ROM Of the knee. Zenith reimbursed \$650.00 per the fee schedule (\$550.00 on line 3 and the \$100.00 which was incorrectly applied to line 1)."

Response Submitted by: The Zenith

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 17, 2017	Designated Doctor Examination	\$100.00	\$100.00

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.

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 performed on or after September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
 - XDC – Workers’ compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment.

Issues

1. What are the services considered in this dispute?
2. Does an unresolved dispute of compensability/liability exist for the disputed services?
3. Is Justin Perish, D.C. entitled to additional reimbursement for the disputed services?

Findings

1. Justin Perish, D.C. is seeking additional reimbursement of \$100.00 for a designated doctor examination to determine maximum medical improvement (MMI) and impairment rating (IR) represented by procedure code 99456-W5-WP and performed on January 17, 2017. While other services were performed and billed for this examination date of service, Dr. Perish is not pursuing a dispute related to these services. Therefore, no other services will be considered in this dispute.
2. On an Explanation of Payment dated February 15, 2017, Zenith Insurance Company (Zenith) denied the disputed services with claim adjustment reason code XDC – “WORKERS’ COMPENSATION CLAIM ADJUDICATED AS NON-COMPENSABLE. THIS PAYER NOT LIABLE FOR CLAIM OR SERVICE/TREATMENT.”

Review of the submitted documentation finds that Zenith did not maintain this denial on subsequent Explanations of Payment or in its position statement. Instead, Zenith made a partial payment for the services in question. The division concludes that an unresolved dispute of compensability/liability does not exist for the disputed services.

3. Per 28 Texas Administrative Code §134.250(3), “The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.” The submitted documentation supports that Dr. Perish performed an evaluation of MMI. Therefore, the maximum allowable reimbursement (MAR) for this examination is \$350.00.

Per 28 Texas Administrative Code §134.250(4), “The following applies for billing and reimbursement of an IR evaluation. ... (C)(ii) The MAR for musculoskeletal body areas shall be as follows. ... (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area.” The submitted documentation supports that Dr. Perish provided an IR, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the bilateral knees. Therefore, the MAR for this examination is \$300.00.

The total reimbursement allowed for the disputed services is \$650.00. Zenith reimbursed \$550.00. An additional reimbursement of \$100.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$100.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$100.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

_____	_____ Laurie Garnes _____	_____ September 22, 2017 _____
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 division 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.