Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-08-1587-01
East Houston Orthopedics and Sports Medicine 12930 East Freeway Houston, TX 77015	DWC Claim #: [redacted] Injured E[redacted]
Respondent Name and Box #: Trans Pacific Insurance Co. Box # 47	Date of I[redacted] Employe[redacted] Insurance [redacted]

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary: "We would like to be paid for impairment rate. Not global."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)
4. Total Amount Sought - $350.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: None submitted.

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
3-8-07	1	99455-V3-WP	1-5	$225.94
Total Due:				$225.94

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011 (a-d), titled *Reimbursement Policies and Guidelines,* and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "1-A charge was made for a visit on the same day as

a surgical procedure, or within the 90-day follow-up period of a previously performed surgery." Per rule 134.202, the impairment rating evaluation is a separate procedure from other services billed on this date.

2. 99455-V3-WP:

   - DWC Rule 134.202(e)(6)(C)(i)(I)(II) states in part: (c) The following applies for billing and reimbursement of an MMI evaluation. (i) An examining doctor who is the treating doctor shall bill using the 'Work related or medical disability examination by the treating physician…" CPT code with the appropriate modifier. (I) Reimbursement shall be the applicable established patient office visit level associated with the examination. (II) Modifiers "V1", "V2", "V3", "V4', or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit."

3. The Requestor is the treating doctor; therefore, the examination was coded correctly using CPT code 99455. Per Rule 134.202(e)(6)(C)(i)(I)(II), the modifier –V3 refers to the applicable office visit. CPT code 99213's MAR is $75.94 in Harris County. Thus, the appropriate reimbursement for the evaluation with modifier-V3 is $75.94.

4. According to Rule 134.202(e)(6)(D)(II), "The MAR for musculoskeletal body areas shall be as follows.
   a) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th Edition is used.
   b) If full physical evaluation, with range of motion is performed:
      1) $300 for the first musculoskeletal body area; and
      2) $150 for each additional musculoskeletal body area.

5. The Requestor did not document a ROM method to determine impairment rating; thus, the appropriate reimbursement for evaluation of one body area is $150.00. This amount plus the MMI evaluation of $75.94 equals $225.94, this amount is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $225.94 plus applicable accrued interest per Division Rule 134.130 due within 30 days of receipt of this Order.

ORDER / DECISION:

[redacted]	[redacted]	4-22-08
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.