



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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

CROWN CHIROPRACTIC

Respondent Name

WEBB COUNTY

MFDR Tracking Number

M4-09-6535-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

FEBRUARY 27, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "At the time of exam [Claimant] continued to suffer pain to a compensable area. In the instance that the patient continues to suffer ongoing pain to not perform range of motion would be negligent. Given this fact of ongoing pain, a range of motion exam was needed to determine appropriate MMI/IR"

Amount in Dispute: \$130.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 24, 2008	CPT Code 99456-WP Designated Doctor Evaluation	\$130.00	\$130.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.4, effective July 27, 2008, requires the insurance carrier to notify providers of contractual agreements for informal and voluntary networks.
- 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - Charges exceed your contracted/legislated fee arrangement.

The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on March 24, 2009. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute

notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Does the documentation support notification requirements in accordance with 28 Texas Administrative Code §133.4?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent reduced payment for the Designated Doctor evaluation based upon "Charges exceed your contracted/legislated fee arrangement."

28 Texas Administrative Code §133.4(g) states "Noncompliance. The insurance carrier is not entitled to pay a health care provider at a contracted fee negotiated by an informal network or voluntary network if:

(1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section; or

(2) there are no required contracts in accordance with Labor Code §413.011(d-1) and §413.0115."

No documentation was provided to sufficiently support that the respondent notified the requestor of the contracted fee negotiation in accordance with 28 Texas Administrative Code §133.4(g).

28 Texas Administrative Code §133.4(h) states "Application of Division Fee Guideline. If the insurance carrier is not entitled to pay a health care provider at a contracted rate as outlined in subsection (g) of this section and as provided in Labor Code §413.011(d-1), the Division fee guidelines will apply pursuant to §134.1(e)(1) of this title (relating to Medical Reimbursement), or, in the absence of an applicable Division fee guideline, reimbursement will be based on fair and reasonable reimbursement pursuant to §134.1(e)(3) of this title."

The Division concludes that the respondent's is not entitled to pay the requestor at a contracted fee reduction; therefore, the disputed services will be reviewed per applicable Division rules and guidelines.

2. On the disputed date of service the requestor billed \$650.00 for CPT code 99456-WP. The issue of this dispute is whether additional reimbursement is due for the Designated Doctor evaluation.

The maximum allowable reimbursement (MAR) for CPT code 99456-WP is:

- 28 Texas Administrative Code §134.204(j)(3) states "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 requestor billed CPT code 99456 because the examination was performed by a designated doctor.

- Per 28 Texas Administrative Code §134.204(j)(4)(C)(iii) states "If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR."

A review of the requestor's billing finds that the "WP" modifier was appended to CPT code 99456 to designate that the provider had performed the MMI examination and the IR testing.

- 28 Texas Administrative Code §134.204(j)(1) states "Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:
 - (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR.
- 28 Texas Administrative Code §134.204(j)(4)(C) states "For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas."
- 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II))a) states "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 requestor billed for MMI/IR of one body area. A review of the Designated Doctor report finds that a full evaluation with range of motion was performed on the lumbar spine; therefore, the MAR is \$300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). Per 28 Texas Administrative Code §134.204(j)(3)(C) the requestor is due \$350.00 for the MMI evaluation, for a total allowable of \$650.00. The respondent paid \$520.00. As a result, the requestor is entitled to reimbursement of \$130.00.

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 \$130.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$130.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

10/29/2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **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. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

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