Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VICTOR KUMAR-MISIR, MD
1718 EAST HEDGECROFT DRIVE
SEABROOK, TEXAS 77586-5836

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-11-4707-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "3 body areas deemed compensable. 3 body areas rated."

Amount in Dispute: $450.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor performed MMI and IR exams 4/28/11. (See requestor's DWC-60 packet) Texas Mutual paid the requestor $350.00 for the MMI exam and $150.00 for IR exam using the spine DRE method. The requestor assessed also the upper and right lower extremities; however, this requestor only billed one unit in Box 24G.

No further payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 28, 2011	99456-W5-WP	$450.00	$0.00

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 31, 2011
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.

   Explanation of benefits dated June 24, 2011
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The provider billed the amount of $950.00 for CPT code 99456-W5-WP for a DD examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that MMI was assigned. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) Category I method on the lumbar and DRE Category II on the cervical is $150.00. Per Texas Administrative Code §134.204(j)(4)(C)(i)(I), lumbar and cervical are one part of one area, the spine. Documentation supports the rating of the upper extremities (wrists) and lower extremities (hips) per AMA Guides to the Evaluation of Permanent Impairment, fourth edition. However, the CMS-1500 billing shows only one unit in box 24G for body areas rated. The combined MAR for the MMI/IR services billed is $500.00.
2. The respondent has already reimbursed the amount of $500.00 for the disputed CPT code 99456-W5-WP. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Gregory Fournerat Medical Fee Dispute Resolution Officer	November 30, 2011 Date

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 **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.