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 and Address

SPINE AND HEALTH INSTITUTE
10109 MCKALLA PLACE STE E
AUSTIN TX 78758

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-13-1021-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per medical fee guidelines."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "If the requestor had billed two units the Texas Mutual would have paid $150.00 for the second unit, per Rule 134.204 (j)(4)(C)(ii)(II). With its request for reconsideration the requestor provided no rational basis for additional payment."

Response Submitted by: Texas Mutual Insurance Company.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 26, 2012	CPT Code 99456 WP W5	$150.00	$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 a medical fee dispute.
2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

   - CAC-W1- Workers compensation fee schedule adjustment.
   - 790- This charge was reimbursed in accordance to the Texas Medical Fee Schedule.
   - 724- No additional payment after a reconsideration of services. For information call 1-800-6824.

Issues

1. Did the insurance carrier pay the correct reimbursement amount to the provider?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code 222- “Charges exceeds fee schedule allowance. “In its position statement, carrier states **“**Based on submitted documentation no additional recommendation is being made…The examining doctor may bill for a maximum of three musculoskeletal body areas…”
    - Per 28 Texas Administrative Code §134.204 (j)(4) (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i)Musculoskeletal body areas are defined as follows:

      (I) spine and pelvis; (II) upper extremities and hands; and, (III)lower extremities (including feet). (ii)The MAR for musculoskeletal body areas shall be as follows. (I)$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used. (II)If full physical evaluation, with range of motion, is performed: (-a-)$300 for the first musculoskeletal body area; and (-b-)$150 for each additional musculoskeletal body area. (iii)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.

    Review of the documentation found that the requestor billed two body areas using three diagnosis codes for CPT code 99456 WP W5. The units billed on “Box G” of the submitted CMS-1500 billed for one unit for date of service 6/26/12. The requestor was reimbursed accordingly.
2. The respondent issued payment in the amount of $300.00. Based upon the documentation submitted, additional no additional reimbursement is recommended.

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

		March 26, 2014
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 28 Texas Administrative Code §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 MDR decision shall deliver a copy of the request 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 §141.1(d).

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