**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**

JEREL BIGGERS
PO BOX 741865
DALLAS TX 75374

**Respondent Name**

UNIVERSITY OF TEXAS SYSTEM

**MFDR Tracking Number**

M4-13-2306-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "99456 WP W5 MMI=$350.00, IR-Upper extremity= $300.00, IR-Lower extremity=$150.00, IR-RIB=$150.00, TTL=$950.00."

**Amount in Dispute:** $150.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Based on submitted documentation no additional recommendation is being made…The examining doctor may bill for a maximum of three musculoskeletal body areas…"

**Response Submitted by:** Injury Management Organization.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 12, 2013 | CPT Code 99456 WP W5 | $150.00 | $150.00 |

## *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

   - 222- Charge exceeds fee schedule allowance.
   - 18- Duplicate claim/service.
   - 193- Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - B13- Previously paid. Payment for this claim/service may have been provided in a previous payment. Previously processed for recommendation.

**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 three body areas for CPT code 99456 WP W5 on date of service 3/12/13.
2. The respondent issued payment in the amount of $800.00. Based upon the documentation submitted, additional reimbursement in the amount of $150.00 is recommended.

**Conclusion**

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

## *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 $150.00 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 | March 21, 2014<br>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**.