



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

KEVIN ELLIS

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-13-2684-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 18, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a position statement to outline the facts of the medical dispute resolution. We performed a Designated Doctor examination on [injured worker] as outline in the DWC-32. This form requested that we perform on MMI and IR exam only.

The report, including the DWC-069, was timely filed by certified mail. The billing codes were proper as outlined in the request for reconsideration forms. As per the medical fee guidelines, \$350 is allowed for the maximum medical improvement evaluation and \$300.00 is allowed for the impairment rating evaluation using the ROM model."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Respondent did not respond the requestors DWC-60 request submission.

Response Submitted by: na

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 05, 2013	CPT Code 99456-W5-WP	\$350.00	\$350.00

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 §134.204 sets out the fee guideline for workers' compensation specific services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowed for another service/procedure that has already been adjudicated
 - 906 – In accordance with clinical based coding edits (National correct coding initiative/outpatient code editor), component code of comprehensive medicine, evaluation and management services procedure (9000-99999) has been disallowed

- QA – the amount adjusted is due to bundling or unbundling of services
- B13 – Previously paid, payment for this claim/service may have been provided in a previous payment
- 247 – A payment or denial has already been recommended for this service
- PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary. The amount adjusted is generally not the patients responsibility, unless the workers compensation state law allows the patient to be billed

Issues

1. Is the requestor entitled to reimbursement for the disputed services performed?

Findings

1. Per 28 Texas Administrative Code §134.204 states (j) 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. The MMI/IR examination shall include...
 - (C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection
 - (3) 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

Review of submitted documentation provided supports an examination addressed Maximum Medical Improvement and Impairment Rating to one body area using range of motion method.
 The total mar for maximum medical improvement for CPT Code 99456-W5-WP is \$350.00. Therefore, additional reimbursement is recommended.

The respondent issued payment in the amount of \$300 for the impairment rating portion. Based upon the documentation submitted, additional reimbursement in the amount of \$350.00 is recommended.

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 \$350.00.

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 \$350.00 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	6/9/14 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.