



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

KAREN SUTTLE MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-13-2902-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

July 01, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... (F) a position statement of the disputed issue(s) that shall include:

- (i) a description of the health care for which payment is in dispute,
DESIGNATED DOCTOR EXAM
- (ii) the requestor's reasoning for why the dispute fees should be paid or refunded,
ACCORDING TO TDI/DWC MEMORANDUM 5/11/2007 AN ADDITIONAL \$150.00 IS DUE"

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "... The following is the carrier's statement with respect to this dispute 2/15/13.

The requestor, as designated doctor, billed \$950.00 for code 99456-WP-W5, for MMI and IR exams. She billed three units. Texas Mutual paid \$350.00 for the MMI exam. The requestor assessed IR of the cervical spine using the DRE method. This is reimbursable at \$150.00, which Texas Mutual paid. The requestor assessed IR of the shoulder; Texas Mutual paid \$300.00 for this. This totals \$800.00 for these two units. However, the requestor billed three units but Texas Mutual, when it reviewed the requestor's documentation, only found two body areas- the spine and shoulder."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 15, 2013	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 medical fee disputes.

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:
 - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
 - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE
 - 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. Did the requestor bill the respondent appropriately for the disputed services performed in accordance with 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor 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
 - (2) An HCP shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Act and Division rules in Chapter 130 of this title
 - (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
- (4) The following applies for billing and reimbursement of an IR evaluation.
 - (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form
 - (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.
 - (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

Documentation provided by the requestor finds the examining doctor that performed the services on February 15, 2013 addressed the following issues (Maximum Medical Improvement, Impairment Rating, Extent of Injury and Return to Work). Review of the report provided indicates Maximum Medical Improvement and Impairment addressed with two musculoskeletal body areas rated using range of motion.

The total MAR for CPT Code 99456 WP-W5 is \$800.00. Therefore, no additional reimbursement is recommended.

2. The respondent issued payment in the amount of \$800.00. Based upon the documentation submitted, 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

Signature

Medical Fee Dispute Resolution Officer

6/9/12

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.