



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

SURESH CHAVDA

Respondent Name

DALLAS AREA RAPID TRANSIT

MFDR Tracking Number

M4-13-3423-01

Carrier's Austin Representative Box

Box Number 15

MFDR Date Received

AUGUST 26, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In addition to the \$350.00 for MMI Assessment the Designated Doctor will charge \$300.00 for the first area of examination and \$150.00 for each additional area of examination... **The total amount that is currently due on this outstanding bill is \$100.00.**"

Amount in Dispute: \$100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon receipt of the MDR, we sent this date of service back for reconsideration and the carrier stands behind its initial payment of \$1150.00 and maintains that no additional allowance is due."

Response Submitted by: ACE Esis.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 5, 2012	CPT Code 99456 WP W5	\$100.00	\$100.00

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

- 2- Previous recommended payment amount on line \$650.00
- 3- This appeal is denied as we find the original review reflected the appropriate allowance for the service rendered. We find that no additional recommendation is warranted at this time. (CIQ378)
- 4- Previous recommended history on DCN(s) 900.5234=\$650.00 (RE555)(RE555).
- 6- Rush bill (E328)
- 7- Previous recommended history on DCN(s) 900.5234 \$500.00 (446,RE555)(RE555)

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 (3)(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.
 - Per 28 Texas Administrative Code §134.204 (4) (C) (ii-iii). (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 one body areas using CPT code 99456 WP W5 for date of service 7/5/12, using the range of motion.

2. The respondent issued payment in the amount of \$550.00. Based upon the documentation submitted, additional reimbursement in the amount of \$100.00 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 \$100.00 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

Date

April 1, 2014

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.