



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

SANTIAGO GUAJARDO

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-14-0438-01

Carrier's Austin Representative Box

Box Number 19

MFDR Date Received

OCTOBER 7, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed a total of \$2,350.00 for this claim and were only \$500.00...Therefore, please issue a payment promptly in the amount of \$1,850.00 to settle this claim."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "MMI-\$350.00 (MMI) IR-\$150.00 (IR for diagnosis related estimated)-amputated arm \$500 owed for MMI/IR. This amount was paid per the EOR and no additional payment is due.."

Response Submitted by: AIG.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 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 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

- 1-(97) The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 1-this procedure is included in another procedure performed in this date. (VA13).

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 – 97 “The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.”
 - 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 (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 line items for CPT code 99456 WP W5. The requestor used one diagnosis code and review of submitted documentation shows only one body area was requested and examined. The requestor was reimbursed accordingly.

2. The respondent issued payment in the amount of \$500.00 for one line item charge for CPT code 99456 WP W5. Based upon the documentation submitted, additional no additional reimbursement is recommended.

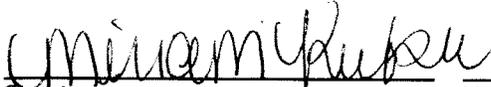
Conclusion

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


Signature

Miriam Rubio
Medical Fee Dispute Resolution Officer

April 1, 2014
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.