



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

YOLANDA BOURGEOIS

Respondent Name

AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number

M4-14-1194-01

Carrier's Austin Representative Box

Box Number 19

MFDR Date Received

December 31, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The total amount that is currently due on this outstanding bill is \$150.00...The disputed service is a Commissioner ordered Designated Doctor evaluation. The service was performed and billed in accordance with the Texas Department of Insurance Fee Schedule for CPT code 99456 WP W5."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Summary: Carrier acknowledged DWC-60, no response submitted.

Response Submitted by: Property & Casualty Ins Co Of

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 6, 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

- *W1- Workers compensation fee schedule adjustment.
- *BL-To avoid duplicate bill denial for all recon/adjustments/additional pymnt requests, submit a copy of this EOR or clear notation that a rec.

Issues

1. Did the insurance carrier pay the correct reimbursement amount to the provider?
2. Is the requestor entitled to reimbursement?

Findings

1. In its position statement the requestor states in pertinent part "The total amount that is currently due on this outstanding bill is \$150.00."
 - 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 four body areas examined. The four areas billed are grouped into two musculoskeletal body areas per 28 Texas Administrative Code §134.204 (j)(4); (1) spine and torso and (2) upper extremity.

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

Date

April 4, 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.