



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

SUZANNE MANZI

Respondent Name

SEABRIGHT INSURANCE CO

MFDR Tracking Number

M4-14-1469-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 27, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Designated Doctor Exam (ii) the requestor's reasoning for why the disputed fees should be paid or refunded, CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS (iii) how the Labor Code, Division rules, and fee guidelines impact the disputed fee issues, and THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: \$300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Suzanne Manzi, MD, served as designated doctor, appointed by the DWC. Based on the EES-14 (aka OA32A), Dr. Manzi was to address the following:

1. Maximum Medical Improvement;
2. Impairment Rating; and
3. Disability"

Response Submitted by: Smith & Carr, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2013	Maximum Medical Improvement and Impairment Rating Examination	\$300.00	\$300.00

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:
 - No explanation of benefits provided

Issues

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

Findings

1. Per 28 Texas Administrative Code §134.204(i)(1)(j)(3) states in pertinent part 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.

Review of submitted documentation provided by the requestor for the services performed on July 26, 2013 were billed with procedure code 99456-WP-W5 with one unit.

Documentation finds the examining doctor performed maximum medical improvement and impairment rating with one body area performed using range of motion method.

Therefore, CPT Code 99456-WP-W5 is supported. The total MAR for CPT code 99456-WP-W5 is \$650.00.

The insurance carrier paid \$350.00, leaving a balance due to the requestor of \$300.00. The requestor is therefore entitled to additional reimbursement of \$300.00

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 \$300.00.

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 \$300.00 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

9/5/14
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.