



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

Tonya Youngblood, MD

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-14-1650-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

February 7, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am requesting that this injured workers claim be reviewed for additional monies per rule 133.250"

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided designated doctor exams on the date above and billed Texas Mutual \$650.00 for code 99456-W5-WP. Texas Mutual paid \$300.00 for the MMI exam and \$150.00 for the IR for the ear a non-musculoskeletal area per (j)(4)(D)(v) of Rule 134.204."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 4, 2013	Designated Doctor Exam to Determine Impairment Rating	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 (j)(4) defines the billing and reimbursement procedures for evaluation of Impairment Rating.
- 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 with the Texas Medical Fee Guideline.

Issues

1. What is the total allowable amount for the impairment rating of the ear?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(4), “The following applies for billing and reimbursement of an IR evaluation. (D) Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR. (i) Non-musculoskeletal body areas are defined as follows: (I) body systems; (II) **body structures** (including skin); and, (III) mental and behavioral disorders. (v) **The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.**” [emphasis added]. The provider supplied a report with an impairment rating only of the left ear, which is considered a body structure. Therefore, the allowable amount for the impairment rating of the ear is \$150.00.
2. The division concludes that the total allowable for the impairment rating of the ear is \$150.00. The respondent issued payment in the amount of \$150.00 for the IR of the ear. 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

	Laurie Garnes	December 4, 2014
Signature	Medical Fee Dispute Resolution Officer	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.