



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

Liza H. Leal, MD

Respondent Name

Zurich American Insurance of Illinois

MFDR Tracking Number

M4-14-2403-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

April 4, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "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 Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on April 14, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 2, 2013	Designated Doctor Exam to Determine Maximum Medical Improvement and Impairment Rating	\$150.00	\$150.00

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 provides the fee schedule for designated doctor examinations.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. What is the total allowable for Maximum Medical Improvement and Impairment Ratings evaluated?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j), "Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: (3)(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." Therefore, the total allowable for evaluation of Maximum Medical Improvement is \$350.00.

Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (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. (D)(i) Non-musculoskeletal body areas are defined as follows: (I) body systems; (II) body structures (including skin); and, (III) mental and behavioral disorders. (iv) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150." The requestor provided impairment ratings, including full physical evaluation with range of motion, for the right/left knees (musculoskeletal lower extremities), the lumbar spine (musculoskeletal spine); and the head (non-musculoskeletal body structure). Therefore, total allowable for impairment rating of the knees is \$300.00. The total allowable for the impairment rating of the spine is \$150.00. The total allowable for the impairment rating of the head is \$150.00.

The total allowable for the exam for Maximum Medical Improvement and Impairment Rating is \$950.00.

2. Review of the submitted documentation finds that the insurance carrier reimbursed \$800.00. The requestor is entitled to additional reimbursement of \$150.00

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 \$150.00.

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 \$150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

December 11, 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.