



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

KEITH BECK MD

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-14-2935-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

May 23, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Please accept the attached claim for RECONSIDERATION for payment at this time for the following rationale ... If MMI has already been established Rule 134.204 (j)(4)(A) indicates the HCP shall include billing components of the IR evaluation WITH the applicable MMI evaluation CPT code. The DWC and the Medical Dispute Resolution has reviewed this matter and has indicated that all "impairment rating only" determinations are to be billed to include the \$350.00 MMI component as well as the Impairment Rating component. Also of note the examination components are classified under the MMI code."

**Amount in Dispute:** \$100.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The following is the carrier's statement with respect to this dispute 11/1/13. The requestor provided DESIGNATED DOCTOR services on the date above and then billed Texas Mutual \$800.00 with code 99456-W5-WP for the MMI and IR exams. Texas Mutual paid \$350.00 for the MMI exam and \$300.00 total (\$150.00 for the eye and \$150.00 for the face) for the two non-musculoskeletal areas rated."

**Response Submitted by:** Texas Mutual Insurance Company

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 01, 2013	CPT Code 99456-W5-WP	\$100.00	\$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 sets out the fee guideline for workers' compensation specific services.
- 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 TO THE TEXAS MEDICAL FEE GUIDELINE

- CAC-W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804. THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

**Issues**

1. What is the maximum allowable reimbursement for the disputed services?
2. Is the requestor entitled to reimbursement?

**Findings**

1. Per 28 Texas Administrative Code §134.204(j)(4)(D)(i)(v) states “The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.” Review of submitted documentation provided finds requestor performed impairment rating examination to two non-musculoskeletal body areas (face and eyes) for the disputed services.

The total allowable reimbursement for the two body areas rated is \$300.00.

2. The respondent issued payment in the amount of \$300.00. 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	11/20/14 Date
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**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.**