



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

John S. Townsend, IV, MD

Respondent Name

Zurich American Insurance Company

MFDR Tracking Number

M4-14-2997-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 30, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "As outlined in DWC Rule 130.204(i) and DWC Rules and Regulations, we are to bill out according to the Medical Fee Guidelines for Workers' Compensation Specific Services.

In researching this claim along with your attached EOB it appears that we did not receive proper reimbursement for evaluation of Impairment Rating. [The injured employee] was evaluated for Maximum Medical Improvement and Impairment Rating for his injury that extends to the Upper Extremities, and Spine and Torso. As outlined in DWC Rule 134.204(j), a reimbursement of \$300 is accepted for evaluation of Impairment Rating for the first body area when using Range of Motion, and a reimbursement of \$150 is accepted for each additional body area.

...Please note that at this time there is an outstanding balance of \$150."

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 June 9, 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
September 30, 2013	99456 W5 WP	\$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 medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the procedures for billing and reimbursing Designated Doctor Examinations.
3. 28 Texas Administrative Code §127.220 provides the requirements for documenting certification of Maximum Medical Improvement and Impairment Ratings.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – Workers compensation state fee schedule adjustment
 - 309 – The charge for this procedure exceeds the fee schedule allowance.
 - OA – The amount adjusted is due to bundling or unbundling of services.
 - W4 – No additional reimbursement allowed after review of appeal/reconsideration/request for second review.
 - W3 – Additional payment made on appeal/reconsideration.
 - 947 R03 – Upheld – No additional allowance has been recommended.

Issues

1. What is the correct MAR for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (j) states, "Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include: (D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets;"

28 Texas Administrative Code §134.204 (j)(3) states, "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." **Review of the submitted documentation supports that the requestor performed an evaluation to determine maximum medical improvement. Therefore, the correct MAR for this examination is \$350.00.**

28 Texas Administrative Code §134.204 (j)(4) states,

(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.

Further, 28 Texas Administrative Code §127.220 (a) states, "Designated doctor narrative reports must be filed in the form and manner required by the division and at a minimum: (2) provide a clearly defined answer for each question to be addressed by the designated doctor examination and only for each of those questions; (3) sufficiently explain how the designated doctor determined the answer to each question within a reasonable degree of medical probability; (4) demonstrate, as appropriate, application or consideration of the American Medical Association Guides to the Evaluation of Permanent Impairment..."

Review of the submitted documentation finds that the requestor performed a full physical examination with range of motion to determine impairment rating of the left shoulder (upper extremity) only. Therefore, the correct MAR for this examination is \$300.00.

2. The total allowable MAR for the examination in dispute is \$650.00. The insurance carrier paid \$650.00. **Therefore, the requestor is not eligible for additional reimbursement.**

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	January 9, 2015
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.