



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

LOVEROUS WHITTAKER DC

Respondent Name

DALLAS COUNTY

MFDR Tracking Number

M4-14-3470-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

July 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We requested a reconsideration from the insurance, JI Companies, for a claim on patient [injured worker], for date of service 05/03/2014 in the amount of \$1100.00, for an Designated Doctor Exam. We received a payment of \$950.00. We submitted a reconsideration request on 06/20/2014, for the balance of \$150.00."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After careful review of the documents submitted and TAC 28 Rule §134.204(j) the third party administrator (TPA) for Dallas County, JI Specialty Services, has determined that our original review stands. The provider examined and provided an impairment rating for four (4) **body parts** which amounts to only three (3) **body areas**. The provider billed four (4) units for 99456-W5-WP with the diagnosis of 845.0 Ankle sprain, 847.0 Sprain of neck, 959.7 Knee, leg, ankle, and foot injury, and 959.3 Elbow, forearm, and wrist injury. Paragraph (4)(C)(i) lists the 3 musculoskeletal body areas as: Spine and pelvis; Upper Extremities and hands; and lower extremities and feet. Stating on page 9 of the report submitted by the provider, the examinations performed for the MMI/IR consisted of a spinal examination, upper extremity examination, and lower extremity examination which would be a total of three (3) body areas. If you review page 13 the report the impairment ratings were for bilateral elbows, bilateral knees, left ankle, and cervical spine which is four 4 **body parts** but still three (3) body areas."

Response Submitted by: JI Specialty Services, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 03, 2014	CPT Code 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

- 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.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
 - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION
 - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME
 - 6466 – BASED ON TAC RULE 134.204(J)(3)(C)AN EXAMINING DOCTOR, OTHER THAN THE TREATING DOCTOR, SHALL BILL USING CPT CODE 99456. REIMBURSEMENT SHALL BE \$350
 - 6467 – BASED ON TAC RULE 134.204(J)(4)(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 IF FULL PHYSICAL EVALUATION, WITH RANGE OF MOTION, IS PERFORMED \$300 FOR THE FIRST MUSCULOSKELETAL BODY AREA; AND \$150 FOR EACH ADDITIONAL MUSCULOSKELETAL BODY AREA
 - 6473 – BASED ON TAC RULE 134.204(J)(4)(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

Issues

1. Is the requestor entitled to reimbursement?

Findings

1. The dispute involves a Designated Doctor Examination, with maximum medical improvement and impairment evaluations performed.

Review of the submitted documentation provided supports impairment rating examination performed for the disputed services in dispute with range of motion for the cervical spine, upper extremity and lower extremity. Review of medical bills provided, the requestor billed with CPT Code 99456-W5-WP with four units in the amount of \$1,100.00.

The total mar allowable for the three musculoskeletal body areas rated using range of motion is \$600.00 in accordance with 28 Texas Administrative Code §134.204(j)(4)(C)(i)(ii)(II)(-a-) \$300 for the first musculoskeletal body area; and (-b-) \$150 for each additional musculoskeletal body area.

The respondent issued payment in the amount of \$600.00 for the impairment rating evaluation. 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	12/30/14 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.