



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

Eugene J. Fontenot, MD

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-15-0601-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

October 14, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Texas Mutual on 09/12/2014, this request was in response to a \$150.00 reduction of the total for the DDE performed on 06/28/2014. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 6/28/2014. The requester billed \$1,415.00; Texas Mutual paid \$1,265.00. The requester believes it is entitled to an additional \$150.00.

The requestor did an IR of the head and one of the lumbar area using the DRE method. Texas Mutual paid the MMI exam and the DRE method, i.e., \$500.00. While it is true the requestor did assess IR of two areas it is also true only one unit was billed.

If the requestor will send a corrected bill with 2 units to the undersigned at the fax number below then additional payment will be issued."

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
June 28, 2014	Designated Doctor Examination	\$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 procedures for billing and reimbursing Designated Doctor Examinations.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
- CAC-P12 – Workers’ Compensation Jurisdictional Fee Schedule Adjustment.
 - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 724 – No additional payment after a reconsideration of services. For information call 1-800-937-6824
 - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

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

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(3), “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.” The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. **Therefore, the correct MAR for this examination is \$350.00.**

28 Texas Administrative Code §134.204 (j)(1) states, “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...” Review of the submitted documentation finds that the requestor performed an evaluation to determine impairment rating for two body areas – lumbar (Spine & Pelvis) and head (Body Systems).

Per 28 Texas Administrative Code §134.204 (j)(4), “The following applies for billing and reimbursement of an IR evaluation. (C)(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. (D)(v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.” The submitted documentation supports that the requestor provided an impairment rating of the lumbar spine based on the DRE Method. While the report indicates that a physical examination with range of motion was performed, it indicates that this was to aid in determining the extent of injury that was also requested, but was not used in finding the impairment rating. **Therefore, the correct MAR for this examination is \$150.00.** The documentation also supports that an examination to determine the impairment rating of a non-musculoskeletal body area – the head. **Therefore, the correct MAR for this examination is \$150.00.**

2. The submitted documentation finds that the requestor correctly billed for the examination to determine Maximum Medical Improvement. 28 Texas Administrative Code §134.204 (j)(4)(A) states, “The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.” The CMS-1500 included in the submitted documentation indicates that the requestor billed for only one (1) unit for Impairment Rating. For this reason, the total recommended reimbursement for the disputed services is \$500.00. The insurance carrier paid \$500.00 for these services. Therefore, the requestor is not entitled to 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

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

January 16, 2015
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.