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
Howard L. Dillard, MD

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-0814-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
November 3, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Texas Mutual on August 5, 2014, this request was in response to a $650 no pay of the $650 for the Designated Doctor Examination performed on July 9, 2014. Unfortunately our request was denied and we are seeking the balance owed to us.

The denial reason(s) per EOB are: Workers Compensation fee schedule adjustment. Designated Doctor Exams are billed according to DWC rule 134.204 and in accordance with labor code 408.004, 408.0041, and 408.151."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of **7/9/2014**.

The requestor, as Designated Doctor, performed MMI and IR exams of the claimant on the date above and then billed Texas Mutual one unit of code 99456-W5-WP. The requestor placed the claimant in DRE category I. For this reason, according to Rule 134.204(j)(4)(C)(ii)(I), Texas Mutual paid the requestor $150.00 for the DRE model found in the AMA Guides 4th edition. However, the requestor seeks reimbursement for the method used at (j)(4)(C)(ii)(II) because (II)(-a-) states 'If full physical evaluation, with range of motion, is performed…$300 for the first musculoskeletal body area…'

In Appeal No. 022509-s, decided November 21, 2002, the Panel stated:

'If the physician cannot decide into which DRE category the patient belongs, the physician may refer to and use the ROM Model, which is described in Section 3.3j (p. 112). (p. 99). Using the procedures of that model, the physician combines an impairment percent based on the patient's diagnosis with a percent based on the patient's spine motion impairment and a percent based on neurologic impairment, if it is present. (p. 99). The physician uses the estimate determined with the ROM Model to decide placement within one of the DRE categories. (p. 99). The proper DRE category is the one having the impairment percent that is closest to the impairment percent determined with the ROM Model. (p. 99).'

The requestor's documentation shows that he used range of motion as a differentiator to place the claimant in a DRE category. While the Guides do allow for use of the Range of Motion Model as a differentiator to place the claimant in a DRE category, the requestor's documentation does not reflect use of the Range of Motion model but only use of range of motion. If the requestor had used the Range of Motion model then his documentation would show the DRE category as the one having the impairment percentage closest to the impairment percentage of the Range of Motion model.

(j)(4)(C)(ii)(II) must be referring to the Range of Motion model. Otherwise the regulatory agency's interpretation of the 4th Edition regarding the use and relationship of the two models is incorrect. Nowhere in the pertinent sections of the Guides does it indicate simple range of motion per se is sufficient as a differentiator to clarify the DRE category."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 9, 2014	Impairment Rating of a Musculoskeletal Body Area	$650.00	$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

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 fee guidelines for Workers' Compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-P12 – Workers Compensation Jurisdictional Fee Schedule Adjustment
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - 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

Issues

1. What is the applicable rule for determining reimbursement for the impairment rating?
2. What is the total allowable amount for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute involves a Designated Doctor Impairment Rating (IR) evaluation of the spine, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4)(C)(ii), which states that "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."

2. 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 total allowable for this examination is $350.00.

   According to the explanation of benefits, the total of $150.00 was reimbursed by the carrier for the IR of the spine. The carrier alleges that this amount was appropriately calculated based upon §134.204(j)(4)(C)(ii)(I). The requestor disagrees. In order for the requestor to be reimbursed pursuant to rule §134.204(j)(4)(C)(ii)(II) (-a-), the health care provider was required to perform a full physical evaluation with range of motion of the spine. Review of the submitted documentation finds that a full physical evaluation with range of motion was performed on the spine. The Division concludes that the impairment rating of the spine is allowed at $300.00 in accordance with the requirements of §134.204(j)(4)(C)(ii)(II)(-a-).

3. The division concludes that the total allowable for the Designated Doctor Examination is $650.00. The respondent issued payment in the amount of $500.00. Based upon the documentation submitted, additional reimbursement in the amount of $150.00 is recommended.

Conclusion

This decision is based upon a review of all the evidence presented by the parties in this dispute. Even though all the evidence was not discussed, it was considered. 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

		January 22, 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.