



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Donald L. Wehmeyer, MD

Respondent Name

Liberty Mutual Fire Insurance

MFDR Tracking Number

M4-15-1072-01

Carrier's Austin Representative

Box Number 01

MFDR Date Received

December 5, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "...I was assigned as a designated doctor to resolve: 1. Maximum medical improvement. 2. Impairment rating...I received the Explanation of Benefits audit date 25 September 2014 in which I charged \$1550.00, and the insurance carrier allowed \$950.00, a difference of \$300.00...I responded with a letter dated 27 October 2014...I also included a new HCFA-1500 marked Request for Reconsideration in which I specifically broke everything down line by line associated with the CPT code...With that packet I included my letter of 28 August 2014, which I had that broken down line by line with the CPT code, etc...I received a new Explanation of Benefits audit date 12 November 2014, in which the insurance company once again denied payment..."

The claimant had multiple injuries to include: 1. Shoulder. 2. Concussion. 3. Auditory hearing loss. 4. Vertigo. 5. Cervical spine injury. 6. Fractured ribs and chest wall deformity. I did identify that ...ribs are part of the spinal column, so that would all be billed under the cervical spine, but the deformity of the chest wall, which is a soft tissue deformity from the surgery, is a significant issue which I have not been paid...I did send back the line by line breakdown with explanation. The insurance company has maintained that they are just not going to pay me. I believe they have improperly audited this claim..."

Amount in Dispute: \$600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee Guidelines and the Texas Department of Insurance Division of Workers' Compensation Acts and Rules. This is not a network claim.

...We have reviewed the reimbursement issued for services of 7/7/14 and have determined that an additional reimbursement of \$200 could be recommended. According to the Medical Fee Guidelines a maximum of three musculoskeletal body areas (units) may be billed. It appears that the provider is billing for body parts and not for body areas as defined by the Division.

The three musculoskeletal body areas are:

Spine and pelvis

Upper extremities and hands

Lower extremities and hands

Also, The provider has billed \$150 each for rating of non-musculoskeletal body areas for which he referred the patient to specialists for testing. According to the medical fee guidelines, this should be billed with an SP modifier and reimbursement would be \$50 and not \$150 each. The EOB has not yet finalized but will be provided when it becomes available."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 7, 2014	Designated Doctor Examination (MMI/IR)	\$600.00	\$250.00

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 fee guidelines for billing and reimbursing Designated Doctor Examinations.
3. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 45 – not defined as required by 28 Texas Administrative Code §133.240
 - Z710 – The charge for this procedure exceeds the fee schedule allowance.
 - P300 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
 - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - W3 – Additional payment made on appeal/reconsideration.

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)(4) states, "(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... (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. (D) ... (i) Non-musculoskeletal body areas are defined as follows: (I) **body systems**; (II) **body structures** (including skin); and, (III) mental and behavioral disorders. (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides... (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150".

Review of the submitted documentation finds that the requestor performed impairment rating evaluations of the cervical spine, the left shoulder, a concussion/traumatic brain injury, sensorineural hearing loss, benign paroxysmal positional vertigo, fractured ribs, scalp laceration, and chest wall deformity. The AMA Guides to the Evaluation of Permanent Impairment (fourth edition) places the concussion in the Nervous System. The hearing loss and vertigo were evaluated based on the Ear, Nose, Throat and Related Structures chapter. The fractured ribs are found in the Respiratory System chapter. The laceration and chest wall deformity were evaluated based on the Skin chapter.

Please see the following chart for a detailed analysis:

Examination	AMA Chapter	§134.204 Category	Reimbursement Amount
Maximum Medical Improvement			\$350.00
IR: Cervical Spine (DRE)	Musculoskeletal System	Spine & Pelvis	\$150.00
IR: Left Shoulder (ROM)		Upper Extremities	\$300.00
IR: Concussion/Traum. Brain Inj.	Nervous System	Body Systems	\$150.00
IR: Hearing Loss	ENT & Related Structures	Body Structures	\$150.00
IR: Vertigo			
IR: Rib fractures	Respiratory System	Body Systems	\$150.00
IR: Scalp Laceration	Skin	Body Structures	\$150.00
IR: Chest Wall Deformity			
Total MMI			\$350.00
Total IR			\$1,050.00
Total Exam			\$1,400.00

2. The total allowable is \$1400.00. The insurance company paid \$950.00 on September 25, 2014 and \$200.00 on December 24, 2014. Therefore, an additional reimbursement of \$250.00 is recommended.

Conclusion

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 \$250.00.

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 \$250.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

April 15, 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.