



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MARK SCHULZ DC

Respondent Name

VIA METROPOLITAN TRANSIT

MFDR Tracking Number

M4-15-1133-02

Carrier's Austin Representative

Box Number 16

MFDR Date Received

December 12, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The following bill was audited and paid incorrectly. TDI-DWC addresses Maximum Medical Improvement (MMI) Evaluations with Rule 134.204 (J) Subsection (3), Subparagraph (C). This rule states to reimburse the examining doctor, other than the treating doctor **\$350.00 for MMI evaluations**. TDI-DWC addresses Impairment Rating (IR) Evaluations with Rule 134.204, Subsection (J), Subsection (4), Subparagraph (C), (ii), (II). This rule states if a full physical evaluation, with range of motion, is performed, reimbursement for the first musculoskeletal body area is \$300.00 and each additional musculoskeletal body are is \$150.00."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The issue is in regards to whether a reimbursement amount is owed for range of motion measurements when the impairment rating billed under procedure code 99456W5WP was determined by the DRE method.

The enclosed medical records do not document a percentage of impairment based on the range of motion measurements. Per Dr. Schultz '...it is determined the examinee's injury is best rated under DRE (Diagnostic Related Estimate) Category I for 0% whole person impairment of the cervical spine; it is determined the examinee's injury is best rated under DRE (Diagnostic Related Estimate) Category I for 0% whole person impairment of the thoracic spine; it is best determined the examinee's injury is best rated under DRE (Diagnostic Related Estimate) Category II for 5% whole person impairment of the lumbar spine.'

According to the Texas Workers' Compensation Medical Fee Guideline 28 TAC §134.204 (j)(C)(ii)(1), the MAR for musculoskeletal body areas shall be \$150.00 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

The prior reimbursement of \$350.00 for maximum medical improvement and \$150.00 for impairment rating was in accordance with the Medical Fee Guideline and no additional allowance is due."

Response Submitted by: Argus Services Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2014	Designated Doctor Examination (MMI/IR)	\$150.00	\$150.00

AMENDED FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

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 schedule for billing and reimbursing Designated Doctor Examinations.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1A – Workers Compensation State Fee Schedule Adjustment *Reimbursement per Rule 134.203/134.204. Prior to March 1, 2008, Rule 134.202*
 - W3W – No reimbursement recommended on reconsideration. Previous recommendation was in accordance with the Workers' Compensation State Fee Schedule.

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.

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. (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area." The submitted documentation indicates that the Designated Doctor performed a full physical evaluation with range of motion for the spine. Therefore, the correct MAR for this examination is \$300.00.
2. The total allowable for the disputed services is \$650.00. Review of the submitted documentation finds that the insurance carrier paid \$500.00. Therefore, the requestor is entitled to additional reimbursement of \$150.00.

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 \$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

Signature

Medical Fee Dispute Resolution Officer

March 6, 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.