



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

Mark Johnson, MD

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-15-1216-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

December 18, 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.

99456 W5 WP MMI = \$350.00
IR – BACK W/ROM = \$300.00
IR – PTSD = \$150.00
IR – BURNS = \$150.00"

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 6/5/14.

The designated doctor billed Texas Mutual code 99456 W5/WP for MMI/IR exams with three units. Texas Mutual paid \$350.00 for the MMI exam and \$450.00 for the Lumbar IR and for the burns IR. This totals \$800.00. Although the designated doctor billed three units only two IRs are documented.

No additional payment is due."

Response Submitted by: Texas Mutual Insurance Carrier

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 5, 2014	Designated Doctor Examination (MMI/IR)	\$150.00	\$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 the fee guidelines 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
 - 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 correct MAR for the services in dispute?
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.

This dispute involves a Designated Doctor Impairment Rating (IR) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4), which states that “(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 indicates that the Designated Doctor performed a full physical evaluation with range of motion for the lumbar spine to find the Impairment Rating. The submitted documentation also finds that the requestor performed impairment rating evaluations of burns and post traumatic stress disorder. 28 Texas Administrative Code §134.204(j)(4)(D)(i) defines skin as a body structure in the non-musculoskeletal category and post traumatic stress disorder is properly placed in the mental and behavioral category. Therefore, the correct MAR for these evaluations is \$600.00. Please see the table below for a detailed analysis.

Examination	§134.204 Category	Reimbursement Amount
Maximum Medical Improvement		\$350.00
IR: Lumbar (ROM)	Spine & Pelvis	\$300.00
IR: Burns	Body Structures (incl. Skin)	\$150.00
IR: Post Traumatic Stress Disorder	Mental & Behavioral	\$150.00
Total MMI		\$350.00
Total IR		\$600.00
Total Exam		\$950.00

2. The total allowable for the disputed services is \$950.00. Review of the submitted documentation finds that the insurance carrier reimbursed \$800.00. 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

Laurie Garnes
Medical Fee Dispute Resolution Officer

March 4, 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.