



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

James Denton, MD

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-15-1218-01

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), (4), (c). 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 area is \$150.00**. This rule goes on to state **when multiple IR's are required as a component of a DDE, the DD shall be reimbursed \$50 for each additional IR calculation. Modifier 'MI' shall be added to CPT code.**"

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 6/13/14.

The requestor as designated doctor performed MMI and IR exams of the claimant on the date above.

The requestor billed 99456-W5/WP at \$800.00 for 2 units. Texas Mutual paid \$350.00 for the MMI exam, \$300.00 for the IR of the first musculoskeletal area, the lumbar spine and hip, and \$150.00 for the second IR, the knee, which totals \$800.00.

Next the designated doctor billed 99456-W5/MI at \$150.00 for three units. These appear to be ratings for conditions the designated doctor determined were unrelated to the compensable injury through the extent of injury exam that was paid...

No additional payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|--|-------------------|------------|
| June 13, 2014 | Designated Doctor Examination (Multiple Impairments) | \$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §127.10 sets out the procedures for Designated Doctor Examinations.
3. 28 Texas Administrative Code §130.1 sets out the procedures for certification of Maximum Medical Improvement and Impairment Rating.
4. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
 - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
 - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
 - 892 – Denied in accordance with DWC rules and/or Medical Fee Guideline including current CPT Code descriptions/instructions.
 - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - No additional payment after a reconsideration of services. For information call 1-800-937-6824.

Issues

1. Did the requestor document the disputed charges appropriately?
2. Is the requestor entitled to reimbursement for the disputed charges?

Findings

1. 28 Texas Administrative Code §127.10 (d) states, "Any evaluation relating to either maximum medical improvement (MMI), an impairment rating, or both, shall be conducted in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment). If a designated doctor is simultaneously requested to address MMI and/or impairment rating and the extent of the compensable injury in a single examination, the designated doctor shall provide multiple certifications of MMI and impairment ratings that take into account each possible outcome for the extent of the injury. A designated doctor who determines the injured employee has reached MMI or who assigns an impairment rating, or who determines the injured employee has not reached MMI, shall complete and file a report as required by §130.1 of this title and §130.3 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment by a Doctor Other than the Treating Doctor). If the designated doctor provided multiple certifications of MMI and impairment ratings, the designated doctor must file a Report of Medical Evaluation under §130.1(d) of this title for each impairment rating assigned ... The designated doctor, however, shall only submit **one narrative report required by §130.1(d)(1)(B) of this title for all impairment ratings assigned** ... All designated doctor narrative reports submitted under this subsection shall also comply with the requirements of §127.220(a) of this title" [emphasis added].

Further, 28 Texas Administrative Code §130.1 (c)(3) states, in relevant part, "... The doctor assigning the impairment rating shall: (B) document specific laboratory or clinical findings of an impairment; (C) analyze specific clinical and laboratory findings of an impairment; (D) compare the results of the analysis with the impairment criteria and provide the following: (i) A description and explanation of specific clinical findings related to each impairment, including zero percent (0%) impairment ratings; and (ii) A description of how the findings relate to and compare with the criteria described in the applicable chapter of the AMA Guides. The doctor's inability to obtain required measurements must be explained."

Additionally, 28 Texas Administrative Code §130.1 (d)(1)(B) states, in relevant part, "The narrative report must include the following: (vi) diagnosis and clinical findings of permanent impairment as stated in subsection (c)(3)."

Review of the submitted documentation finds that the requestor did not document the disputed charges in the narrative report appropriately.

2. Based on the information above, the division finds that the requestor is not entitled to reimbursement for the disputed charges.

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

| | | |
|-----------|--|----------------------|
| | Laurie Garnes | March 4, 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.