



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

Phillip W. Landes, MD

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-15-1309-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

December 30, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received partial payment for this bill; the denial for the balance stated: 'WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT; THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.' However, this claim was not paid according to the MFG recommended allowance. This bill is for a Division-ordered Designated Doctor Exam; the attached DWC-32 requested an exam to determine the claimant's Maximum Medical Improvement (MMI), and Impairment Rating (IR).

99456-W5-WP was the CPT code & modifiers used because: a doctor other than the treating doctor examined the injured worker; the doctor was acting as a TDI-DWC appointed designated doctor; the exam performed by the doctor was to determine MMI **and** IR; the injured employee is at MMI; the designated doctor is billing for the whole procedure of impairment rating; the doctor is eligible for 100% of the MAR for the exam. **99456-SP** was used to indicate that Dr. Landes referred the injured worker to a specialist and incorporated the results from the specialist into his report.

Per 28 TAC §134.204, parts (j)(4)(D)(iii)(I):

(j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) exam shall be billed and reimbursed as follows:

(4) The following applies for billing and reimbursement of an IR evaluation.

(D) non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR.

(iii) When the examining doctor refers testing for non-musculoskeletal body area(s) to a specialist, then the following shall apply:

(I) The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier 'SP' and indicate one unit in the 'units' column of the billing form. Reimbursement shall be \$50 for incorporating one of more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination.

Dr. Landes referred the claimant for an ophthalmology evaluation with Dr. David Tasker and included the results (from Dr. Tasker's 6/14/14 exam) into his designated doctor report, and he incorporated those findings into his calculation of the impairment rating; thus, the remaining \$50.00 should be reimbursable for the 99456-SP line item.

We billed a total of \$1,000.00 for these services. We have only received payment of \$850.00 from your company. Please issue payment in the amount of \$150.00 to settle this claim."

Amount in Dispute: \$100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 5/27/14.

The designated doctor billed 3 units of 99456-W5/WP. This is billing for IRs of non-musculoskeletal areas. Rule 134.204 at (v)(D)(v) states the MAR for the assignment of an IR in a non-musculoskeletal body is \$150.00. Texas Mutual paid \$150.00 for each of the three units billed, i.e. \$450.00, yet the requestor insists on an additional \$150.00 is due but fails to state the reason.

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
May 27, 2014	Designated Doctor Examination (IR)	\$100.00	\$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 §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 total allowable for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (j)(4)(A) states, "The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. **The number of body areas rated shall be indicated in the units column of the billing form**" [emphasis added]. Further, 28 Texas Administrative Code §134.204 (j)(4)(D)(v) states, "The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150."

The requestor billed for three (3) units for impairment rating of non-musculoskeletal body areas. Therefore, the total allowable for the disputed services is \$450.00.

2. The total allowable is \$450.00. Review of the submitted documentation finds that the insurance carrier paid \$450.00. Therefore, no further reimbursement is recommended.

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

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

March 12, 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.