



**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](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

Robert Panzarella, MD

**Respondent Name**

Arch Insurance Company

**MFDR Tracking Number**

M4-15-1400-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

January 8, 2015

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The claim for this patient in the amount of \$1250.00 was filed via fax to Arch Ins. Co. on 12/04/2014.

Payment of \$950 was received with a reduction of \$300.00.

\$150.00 reduction was taken for W5/WP on each of the two additional body parts listed on the CMS-1500/Field 24-Lines 2 and 3.

I would like to file a Medical Fee Dispute Resolution Request for full payment."

**Amount in Dispute:** \$300.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Our supplemental response for the above referenced medical fee dispute resolution is as follows: the bills in question were escalated and the review has been finalized. Our bill audit company has determined no further payment is due. Please see below for rationale behind their denial.

DOS: 11/26/14

Provider is disputing none payment of 99456/W5.WP \$150 x2. Review of the bills shows both of these lines were allowed in full.

99456/W5.WP.RM \$650.00 3 Units Of Service billed – line was priced correctly

3 areas Upper and lower extremities and spine RM 300 Upper lower 150 and DR spine 150

99456/W5.WP.RM \$150 allowed at billed charge

99456/W5.WP.DR \$150 allowed at billed charge

Per review of the attached the provider is billing Upper and lower extremities and spine ROM and Spine DR.

\$350 (W5) + \$300 (first body area treated) = \$650

\$150 (second body area treated)

\$150 (additional body area treated)

<http://www.tdi.texas.gov/wc/rules/documents/wcrules.pdf>

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

(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.

(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.

(I) \$150 for each body area if the Diagnosis Related Estimates (DRE method found in the AMA Guides 4<sup>th</sup> edition is used.

(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

Bill is priced correct.”

**Response Submitted by:** Gallagher Bassett

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 26, 2014	Designated Doctor Examination (MMI/IR)	\$300.00	\$300.00

### **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:
  - P1 – No explanation as required by 28 Texas Administrative Code §133.240 (f)(17)(H). ASCII defines this code as follows: State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.
  - 18 – Duplicate claim/service
  - U301 – No explanation as required by 28 Texas Administrative Code §133.240 (f)(17)(H).
  - Z362 – No explanation as required by 28 Texas Administrative Code §133.240 (f)(17)(H).

#### **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.

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 finds that the requestor performed impairment rating evaluations of the cervical spine, the thoracic spine, the lumbar spine, bilateral shoulders, the left foot, the teeth, and lacerations of the scalp/face. The AMA Guides to the Evaluation of Permanent Impairment (fourth edition) places the teeth in the Ear, Nose, Throat, and Related Structures chapter. For this reason, it is considered a body structure in the non-musculoskeletal category. The Guides places the lacerations of the scalp and face in the chapter for Skin, which is considered a body structure according to §134.204 (j)(4)(D)(i)(II). Therefore, the correct MAR for the total Impairment Rating examination is \$900.00. See the table below for detailed analysis:

Examination	§134.204 Category	Reimbursement Amount
Maximum Medical Improvement		\$350.00
IR: Cervical (DRE)	Spine & Pelvis	\$150.00
IR: Thoracic (DRE)		
IR: Lumbar (DRE)		
IR: Bilateral Shoulders (ROM)	Upper Extremities	\$300.00
IR: Left Foot (ROM)	Lower Extremities	\$150.00
IR: Teeth	Body Structures	\$150.00
IR: Scalp/Face Lacerations	Body Structures	\$150.00
<b>Total MMI</b>		<b>\$350.00</b>
<b>Total IR</b>		<b>\$900.00</b>
<b>Total Exam</b>		<b>\$1,250.00</b>

2. The total allowable for the disputed services is \$1250.00. Review of the submitted documentation finds that the insurance carrier paid \$950.00. Therefore, the requestor is entitled to an additional reimbursement of \$300.00.

**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 \$300.00.

***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 \$300.00 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 17, 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.**