



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

Michael W. Mann, MD

Respondent Name

New Hampshire Insurance Company

MFDR Tracking Number

M4-15-1587-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 28, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Gallagher Basset on 12-12-2014, this request was in response to a \$165.00 reduction of the \$1465.00 for the DDE performed on 01-30-2014. Unfortunately our request was denied and we are seeking the balance owed to us.

The denial reason(s) per EOB are: Workers Compensation fee schedule adjustment. Designated Doctor Exams are billed according to DWC rule 134.204 and in accordance with labor code 408.004, 408.0041, and 408.151."

Amount in Dispute: \$165.00

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 that regarding CPT 99080-73, additional money is owed. Additional \$15.00 was recommended and paid to you on 02/27/15, with check #0116711530."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2014	Designated Doctor Examination (MMI/IR) & Work Status Report	\$165.00	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
- 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 20 – (206) National Provider Identifier - missing

- 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.

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 finds that the requestor performed impairment rating evaluations of the cervical spine, thoracic spine, right shoulder, right elbow, and concussion. The cervical and thoracic spine are combined into the Spine and Pelvis category per §134.204(j)(4)(C)(i)(I). The right shoulder and right elbow are combined into the Upper Extremity category per §134.204(j)(4)(C)(ii)(II). Documentation indicates that a full physical examination with range of motion was performed on the spine and upper extremity. The AMA Guides to the Evaluation of Permanent Impairment (fourth edition) places the concussion in the Nervous System chapter. For this reason, it is considered a body system in the non-musculoskeletal category per §134.204(j)(4)(D)(i)(I). See the table below:

Examination	§134.204 Category	Reimbursement Amount
Maximum Medical Improvement		\$350.00
IR: Cervical (ROM)	Spine & Pelvis	\$300.00
IR: Thoracic (ROM)		
IR: Right Shoulder (ROM)	Upper Extremities	\$150.00
IR: Right Elbow (ROM)		
IR: Concussion	Body Systems	\$150.00
Total MMI		\$350.00
Total IR		\$600.00
Total Exam		\$950.00

2. Review of the submitted documentation finds that the insurance carrier paid \$15.00 for CPT Code 99080-73. Therefore, no further reimbursement is recommended for this CPT Code.

Review of the submitted documentation finds that the total allowable for CPT Code 99456-W5-WP is \$950.00. The insurance carrier paid \$800.00. Therefore, additional reimbursement of \$150.00 is recommended.

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 13, 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.