



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Norri J. Collier, DC

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-15-1784-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

February 17, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I received a denial for the balance of this bill stating 'WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT; CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERRORS NEEDED FOR ADJUDICATION; THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED; DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS'. However, this is incorrect, since the payment made did not meet the MFG recommended reimbursement, and the procedure performed during the exam was billed using the correct CPT code & modifiers.

99456-MI was used to indicate that TDI-DWC requested multiple impairment ratings. Per 28TAC§134.204(j), the Medical Fee Guidelines recommended reimbursement for this assessment is \$50.00.

We billed a total of \$1,150.00 for these services. *We have only received \$1,100.00 from your company, which does not meet the Medical Fee Guidelines suggested payment amount of \$1,150.00. Please issue prompt payment in the amount of \$50.00 to settle this claim.*"

Amount in Dispute: \$50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 4/16/2014.

The requestor billed Texas Mutual for 99456-W5/NM, 99456-W6/RE, 99456-W8/RE, and 99456-MI. Texas Mutual paid the MAR for 99456-W6/RE, 99456-W8/RE, and paid the requestor's charge of \$350.00 for 99456-W5/NM.

Texas Mutual declined payment of 99456-MI absent a calculation of impairment. Rule 134.204(j)(4)(B) states, 'When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed \$50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code.' The requestor states in his narrative report the claimant 'has not reached Maximum Medical Improvement.' The statement 'has not reached Maximum Medical Improvement' is not a rating for which reimbursement can be issued."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 16, 2014	Designated Doctor Examination for Multiple Impairment Ratings	\$50.00	\$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. 28 Texas Administrative Code §127.10 sets out the procedures for Designated Doctor Examinations.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-W1 – Workers' Compensation State 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.
 - 724 – No additional payment after a reconsideration of services.
 - CAC-P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
 - CAC-18 – Exact duplicate claim/service.
 - 736 – Duplicate appeal. Network contract applied by Texas Star Network.

Issues

1. Are the disputed services supported in the documentation?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (j)(4)(B) states, in relevant part, "When multiple IRs are required as a component of a designated doctor examination ..., the designated doctor shall bill for the number of body areas rated and be reimbursed \$50 for each additional IR calculation..." [emphasis added]. Review of the submitted documentation finds that the requestor performed one impairment rating calculation for the compensable injury, but that this is not reflected in the Report of Medical Evaluations (DWC069) as required by 28 Texas Administrative Code §127.10 (d). Therefore, this impairment rating is not billable. There are no other calculations of impairment rating documented. Therefore, multiple IRs, as described in 28 Texas Administrative Code §134.204 (j)(4)(B) is not supported.
2. Because the requestor did not support the disputed services, 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 27, 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.