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
Steve Min Gao, MD

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-1902-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 24, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to Texas Mutual on 11-26-2014, this request was in response to a $150.00 reduction of the $1200.00 for the DDE performed on 10-18-2014. 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: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 10/18/14.

The requestor billed one unit code 99456-W5/WP. Texas Mutual paid $350.00 for the MMI exam. The requestor assessed impairment for a hernia. Rule 134.204 at (j)(4)(D)(v) states the MAR for the assignment of an IR in a non-musculoskeletal body area is $150.00. Texas Mutual paid the $150.00."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 18, 2014	Designated Doctor Examination	$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 §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.
   - CAC-18 – Exact duplicate claim/service.
   - 736 – Duplicate appeal. Network contract applied by Texas Star Network.

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)(D), which states that "(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 digestive system and the reproductive system. Therefore, the correct MAR for these examinations is $300.00. However, the requestor billed for only one unit. Thus, the total allowable is $150.00.

   28 Texas Administrative Code §134.204 (j)(4)(B) states, "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. Modifier "MI" shall be added to the MMI evaluation CPT code." The submitted documentation indicates that the Designated Doctor was ordered to address Maximum Medical Improvement, Impairment Rating, and Extent of Injury. The narrative report and enclosed forms support that these examinations were performed, and two additional impairment ratings were provided appropriately. Therefore, the correct MAR for this service is $100.00. However, the requestor billed for only one unit. For this reason, the total allowable is $50.00.

   Per 28 Texas Administrative Code §134.204 (k), "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee." The submitted documentation indicates that the Designated Doctor performed an examination to determine Extent of Injury. Therefore, the correct MAR for this examination is $500.00.
2. The total allowable for this Designated Doctor Examination is $1050.00. Review of the submitted documentation finds that the insurance carrier paid $1050.00. 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

	Laurie Garnes	April 7, 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.