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
Melburn K. Huebner, MD

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-2034-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 4, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have received your EOB and we are requesting that you reconsider the reduction that was taken. This was for a Designated Doctor determination of MMI and Impairment. I have enclosed copies of the guidelines per Chapter 130, Paragraphs 3 & 4 and another copy of his evaluation. **The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement ($350.00) plus the reimbursement for the body area(s), see Section 4 C, evaluated fro the assignment of an IR, the first body are is $300.00.** The rate for RME's is $500.00. We bill from the guidelines and as this is a work related injury we do not accept the usual and customary deductions or any PPO deductions as we are not under any contracts.

Please reconsider the reimaging balance as we are charging according to the Texas Medical Fee Guidelines. The documentation was sent with the original HCFA form."

Amount in Dispute: $680.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of **6/9/2014.**

The requestor as designated doctor performed MMI/IR exams on the date above then billed Texas Mutual for this. Texas Mutual declined to issue payment for the exams as the DWC69 is inconsistent with the billing date and the date of the narrative report.

The requestor billed a computerized hand strength evaluation. Hand strength testing is a component of testing outlined in the AMA Guides. No separate payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 9, 2014	Designated Doctor Examination (MMI & IR)	$680.00	$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 §130.1 defines the requirements for certification of Maximum Medical Improvement and Impairment Rating.
4. 28 Texas Administrative Code §127.10 sets out the general procedures for Designated Doctor Examinations.
5. 28 Texas Administrative Code §127.220 provides the requirements for Designated Doctor Reports.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   For CPT Code 99456-W5-WP:
   - 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.
   - CAC-P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
   - 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.
   - 892 – Denied in accordance with DWC Rules and/or Medical Fee Guideline including current CPT Code descriptions/instructions.
   - CAC-18 – Exact duplicate claim/service.
   - 736 – Duplicate appeal. Network contract applied by Texas Star Network.

   For CPT Code 95832:
   - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217 – The value of this procedure is included in the value of another procedure performed on this date.
   - 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. Did the requestor document the disputed services according to 28 Texas Administrative Code §130.1?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied payment for the Designated Doctor Examination (CPT Code 99456-W5-WP), in part, stating, "Claim/service lacks information or has submission/billing error(s) which is needed for adjudication" and "The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information."

   Review of the submitted documentation indicates that the requestor was acting as a Designated Doctor under an order from the Division of Workers' Compensation, dated May 23, 2014 for date of service June 9, 2014. Review of the submitted narrative finds that the requestor performed both the professional and technical components of Impairment Rating testing. Per 28 Texas Administrative Code §134.204, this information is correctly reflected in the billing for services using CPT Code 99456 (examination by a doctor other than the treating doctor), with modifier "W5" (a designated doctor evaluation of Maximum Medical Improvement and/or Impairment Rating), and modifier "WP" (indicating that the examining doctor performed the entire examination to determine impairment).

   28 Texas Administrative Code §130.1 (d)(1) states, "Certification of MMI, determination of permanent impairment, and assignment of an impairment rating (if permanent impairment exists) for the current compensable injury requires completion, signing, and submission of the Report of Medical Evaluation and a narrative report." The submitted Report of Medical Evaluation (DWC-069) indicates that the applicable date of service for that report is January 21, 2014 and that Dr. Melburn K. Huebner was acting as a "Doctor selected by Treating Doctor acting in place of the Treating Doctor." Therefore, the submitted DWC-069 is not for the service in dispute. For this reason, the requestor did not document the disputed services according to 28 Texas Administrative Code §130.1.
2. Because CPT Code 99456-W5-WP was not documented appropriately, no reimbursement is recommended for this code.

Additionally, manual strength testing of the hand (CPT Code 95832) was denied by the insurance carrier, stating, "The value of this procedure is included in the value of another procedure performed on this date." 28 Texas Administrative Code §134.204 (j)(5) states, "If the examination for the determination of MMI and/or the assignment of IR requires testing that is not outlined in the AMA Guides, the appropriate CPT code(s) shall be billed and reimbursed in addition to the fees outlined in paragraphs (3) and (4) of this subsection." The AMA Guides outline manual strength testing in Chapter 3, pages 64-65. Therefore, no reimbursement is recommended for this code.

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	April 14, 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.