



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

Charles F. Case, DC

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-15-2136-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

March 16, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I received partial payment for this bill; the denial for the remainder states 'WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT; THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICCAL FEE GUIDELINE.' However, this is incorrect: The payment we received from your company does not meet the MFG suggested reimbursement amount for the services provided.

99456-W5-WP: a doctor other than the treating doctor examined the claimant; the doctor was a TDI-DWC appointed designated doctor; the exam performed was to determine MMI and IR; the injured employee is at MMI; the designated doctor is billing for the whole procedure of IR measurements; the doctor is eligible for 100% of the MAR for the exam, *per 28 TAC §134.204(j)*.

We billed a total of \$1,150.00 for these services. *We have only received \$1,000.00 from your company.* **Please issue payment in the amount of \$150.00 to settle this claim.**"

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 12/9/14.

The requestor as designated doctor performed MMI/IR exams of the claimant on the date above. Texas Mutual paid \$350.00 for the MMI exam and \$150.00 for the IR exam. The requestor, however, seeks a total payment of \$300.00 for the IR exam yet provided no documentation of any range of motion. No additional payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 9, 2014	Designated Doctor Examination (MMI/IR/EOI)	\$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.

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.

Per 28 Texas Administrative Code §134.204 (j)(4), “The following applies for billing and reimbursement of an IR evaluation. (C)(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 4th edition is used. (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area.” Review of the submitted documentation finds that the Impairment Rating performed was for the lower extremity, applying “Table 37, page 77” of the AMA Guides, 4th edition. The range of motion performed was for the lumbar spine, which did not receive an impairment rating. Therefore, the correct MAR for this examination is \$150.00.

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 the disputed services is \$1000.00. Review of the submitted documentation finds that the insurance carrier paid \$1000.00. 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

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

April 21, 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.