



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Tonya Youngblood, M.D.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-15-3908-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

August 3, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... this request was in response to a \$150.00 reduction of the \$150.00 for the DDE performed on 3-11-15. Unfortunately our request was denied and we are seeking the balance owed to us."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester, as designated doctor, conducted MMI and IR exams of the claimant on the date above. The requestor billed three units of 99456-W5/WP. Texas Mutual paid \$350.00 for the MMI exam, \$300.00 for the range of motion to the lower extremity, and \$150.00 for the range of motion to the upper extremity. The documentation does not identify a third body assessed. Absent such 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
March 11, 2015	Designated Doctor Examination	\$150.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 guidelines for billing and reimbursing Division-specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment 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 Maximum Allowable Reimbursement (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 requestor performed an evaluation of Maximum Medical Improvement. 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. (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area. (-b-) \$150 for each additional musculoskeletal body area.” The submitted documentation indicates that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion for the right knee (lower extremity) and left arm/hand/fingers (upper extremity). Therefore, the correct MAR for this examination is \$450.00.

Though the requestor included charges for multiple impairments and an examination for extent of the compensable injury on the Medical Fee Dispute Resolution Request (DWC060), the disputed amount for these services is \$0.00. Therefore, these services will not be considered.

2. The total MAR for the disputed services is \$800.00. The insurance carrier paid \$800.00. 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

September 4, 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, 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 MFDR 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.