



# 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**

Nathaniel Greenwood, D.O.

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-16-0049-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

September 8, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "... this request was in response to a \$149.97 reduction of the \$1165.00 for the DDE performed on 03/11/2015."

**Amount in Dispute:** \$149.97

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requester, as designated doctor, certified the claimant reached MMI with 0% IR. The documentation identified the area assessed as 0% was to the lungs, a non-musculoskeletal area that Texas Mutual paid \$150.00. 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	\$149.97	\$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 fee guidelines for 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. This dispute involves reduction of payment for examinations to determine maximum medical improvement (MMI), impairment rating (IR), the ability of the injured employee to return to work (RTW), and charges for a work status report.

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.

28 Texas Administrative Code §134.204(j)(4), which states that:

(D) ...

(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 lungs. The AMA Guides to the Evaluation of Permanent Impairment (fourth edition) places the lungs in the respiratory system chapter. For this reason, the Division categorizes the lungs as a body system in the non-musculoskeletal category. 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 the injured employee’s ability to return to work. Therefore, the correct MAR for this examination is \$500.00.

Per 28 Texas Administrative Code §134.204 (l), “The following shall apply to Work Status Reports. When billing for a Work Status Report **that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section** [emphasis added], refer to §129.5 of this title (relating to Work Status Reports)”. Therefore, the filing of the DWC-073 is not payable when provided in conjunction with a Designated Doctor Examination performed according to 28 Texas Administrative Code §134.204 (i).

2. The total MAR for the disputed services is \$1000.00. The insurance carrier paid 1015.00. 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 30, 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.**