TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Adam Alexander, D.C.

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-16-0158-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
September 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… the payment issued to us does not meet the recommended allowance as set by the Texas Medical Guideline, as there was no payment allowed for third scenario of the multiple impairment ratings performed."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "**Pursuant to division rule §134.204(n)(5)** MI, Multiple Impairment Ratings—This modifier shall be added to CPT Code 99455 when the designated doctor is required to complete multiple **impairment ratings calculations.**' In this case the Designated Doctor determined that the injured employee was not at MMI in all 'scenarios' by billing CPT code 99456 NM, therefore there is no ***calculation*** of an impairment rating(s) and therefore is not reimbursable."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 5, 2015	Designated Doctor Examination	$50.00	$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

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 Division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 309 – The charge for this procedure exceeds the fee schedule allowance.

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. What is the Maximum Allowable Reimbursement for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. While charges for CPT codes 99456-W5-NM, 99456-W6-RE, and 99456-W8-RE were included on the Medical Fee Dispute Resolution Request (DWC060), the requestor is seeking $0.00 for these charges. Therefore, they will not be considered in this dispute. This dispute involves CPT code 99456-MI for multiple impairments.

   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** [emphasis added]. 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 do not support that impairment rating (IR) calculations were performed. Therefore, the MAR for this code is $0.00.

2. The MAR for the disputed services is $0.00. The insurance carrier paid $100.00. 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	October 23, 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, 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.