



# 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**

Ronald D. Linderman, D.C.

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-16-1608-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

February 11, 2016

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The appropriate billing charges by me were submitted and I was not paid in accordance with the DWC rules."

**Amount in Dispute:** \$300.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requestor billed one unit each of 99456W5,WP and 99456W8,RE. Texas Mutual paid \$350.00 for the MMI exam, \$300.00 for the IR exam, and \$500.00 for the return to work exam. No additional payment is due based on the coding provided."

**Response Submitted by:** Texas Mutual Insurance Company

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 30, 2015	Designated Doctor Examination	\$300.00	\$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 submitted documentation did not include an explanation of benefits from the insurance carrier.

### Issues

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement for the disputed services?

### 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 supports 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 ...

- (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The **number of body areas rated shall be indicated in the units column of the billing form** [emphasis added].
- (B) ...
- (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
  - (i) Musculoskeletal body areas are defined as follows:
    - (I) spine and pelvis;
    - (II) upper extremities and hands; and,
    - (III) lower extremities (including feet).
  - (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.
      - (-b-) \$150 for each additional musculoskeletal body area.

The submitted documentation indicates that the requestor provided an impairment rating and performed a full physical evaluation with range of motion for the foot, left shoulder, and cervical spine. Review of the submitted billing indicates that the requestor is seeking reimbursement for one unit. Therefore, the correct MAR for this examination is \$300.00.

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 ability of the injured employee to return to work. Therefore, the correct MAR for this examination is \$500.00.

2. The total MAR for the disputed services is \$1150.00. The insurance carrier paid \$1150.00 for the services in question. 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**

_____	<u>Laurie Garnes</u>	<u>March 14, 2016</u>
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.**