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
Cesar P. Duclair, M.D.

Respondent Name
ACE American Insurance Company

MFDR Tracking Number
M4-16-2534-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
April 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION/PARTIAL PAY"

Amount in Dispute: $750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent paid Requestor the correct amount for the MMI, impairment rating, return to work, and extent of injury examination for the date of service 12/9/14.

In conclusion, no additional reimbursement is owed to Requestor."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2015	Designated Doctor Examination	$750.00	$150.00

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:
   - P1
   - P12
   - W3 – Request for reconsideration
   - Z710

Issues

1. What services are considered in this dispute?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. While the requestor included procedure codes 99456-W5-MI, 99456-W6-RE, 99456-W8-RE, and 99080-73 on date of service December 12, 2015 on the Medical Fee Dispute Resolution Request (DWC060), the requestor is seeking $0.00 for these services. The requestor is seeking $750.00 for procedure code 99456-W5-WP on date of service December 12, 2015. Therefore, this is the only service considered for this dispute.

2. 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.

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

   (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…
     - (II) If full physical evaluation, with range of motion, is performed:
       - (-a-) $300 for the first musculoskeletal body area; and
       - (-b-) $150 for each additional musculoskeletal body area.

   (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 cervical/thoracic/lumbar spine, left and right wrists, left and right ankle/foot, and the head. The MAR for these examinations is:

Examination	AMA Chapter	§134.204 Category	Reimbursement Amount
Maximum Medical Improvement			$350.00
IR: Cervical Spine (ROM)	Musculoskeletal System	Spine & Pelvis	$300.00
IR: Thoracic Spine (ROM)			
IR: Lumbar Spine (ROM)			
IR: Left Wrist (ROM)		Upper Extremities	$150.00
IR: Right Wrist (ROM)			
IR: Left Ankle/Foot (ROM)		Lower Extremities	$150.00
IR: Right Ankle/Foot (ROM)			
IR: Head	Nervous System	Body Systems	$150.00
Total MMI			**$350.00**
Total IR			**$750.00**
Total Exam			**$1,100.00**

3. The total MAR for the disputed services is $1,100.00. Submitted explanations of benefits find that the insurance carrier paid $950.00. An additional reimbursement of $150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	May 20, 2016
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.