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
John D. Kirkwood, D.O.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-3466-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 18, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Review of submitted documentation finds that the doctor performed an evaluation of **Maximum Medical Improvement and Impairment Rating** for two (2) body areas *$235.00* – one (1) Musculoskeletal body areas [sic] with **Range of Motion ROM** *Upper Extremities,* left wrist/finger *$300.00* – one (1) Non-Musculoskeletal body area with **Diagnosis Related Estimate DRE** *Body Structure* Scarring *$150.00* for total allowable of *$685.00*. The insurance carrier paid $533.78. I am requesting reimbursement for an additional $150.00, for a total reimbursement of $685.00."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed two units of 99455-WP/V5. However, the documentation shows assessment one area, the left upper extremity, and no other area."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 21, 2016	Treating Doctor Examination to Determine Maximum Medical Improvement & Impairment Rating	$150.00	$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 §133.305 sets out the requirements for medical disputes.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
4. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.

5. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
6. 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. Does a network issue exist for this dispute?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier asserted in its position statement that the division does not have jurisdiction in this case due to a network issue. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as:

   > A dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury.

   Per 28 Texas Administrative Code §133.240(f)(15), an insurance carrier is required to indicate that the claim is part of a network on the explanation of benefits. Review of the submitted documentation does not find that the insurance carrier included network status on explanations of benefits for the services in question. The division finds that the insurance carrier's assertion is not supported. Therefore, a network issue does not exist for this dispute.

2. 28 Texas Administrative Code §134.204(j)(3) states, in relevant part:

   > The following applies for billing and reimbursement of an MMI evaluation.
   > (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.
   > (i) Reimbursement shall be the applicable established patient office visit level associated with the examination.
   > (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.

   The requestor is seeking reimbursement for procedure code 99455-WP-V5. For this reason, reimbursement corresponds with procedure code 99215, which is subject to the reimbursement guidelines found in 28 Texas Administrative Code §134.203, which states, in relevant part:

   > (c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…
   > (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2016 is $56.82.

   For procedure code 99215 on January 21, 2016, the relative value (RVU) for work of 2.11 multiplied by the geographic practice cost index (GPCI) for work of 1.019 is 2.1501. The practice expense (PE) RVU of 1.81

multiplied by the PE GPCI of 1.006 is 1.8209. The malpractice (MP) RVU of 0.15 multiplied by the MP GPCI of 0.955 is 0.1433. The sum of 4.1143 is multiplied by the Division conversion factor of $56.82 for a MAR of $233.78.

In addition, 28 Texas Administrative Code §134.204(j)(4) states, in relevant part:

(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; 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…

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 left upper extremity with range of motion, and scarring, using Chapter 13 of the AMA Guides. For this reason, the MAR for this examination is $450.00.

3. The total MAR for the disputed services is $683.78. The insurance carrier paid $533.78. An additional $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 on the submitted information, pursuant to Texas Labor Code Sec. 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	XXX
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.