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
JESSE O. SCHNERINGER DC

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-18-3781-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
JUNE 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "During our training by the TDI-DWC we were instructed to perform multiple impairments anytime EOI is ordered, please see my DWC 69 forms. Three separate impairment/DWC-69 were done for compensable by itself, disputed by itself, and compensable + disputed. Therefore re-imbursement should have been $50 for the 2nd and 3rd impairment/DWC-69 for a total of $100, please see information from DWC billing guidelines."

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor is requesting reimbursement for performing multiple impairment ratings. However, Requestor did not assign an impairment rating because the Claimant was found not to be at MMI. Therefore, no impairment rating could be assigned."

Response Submitted By: Downs Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 15, 2018	CPT Code 99456-W5-MI (X2) Maximum Medical Improvement/Impairment Rating Evaluation	$100.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 §134.250, effective July 7, 2016, sets the reimbursement guidelines for Maximum Medical Improvement Evaluations and Impairment Rating Examinations.
3. The services in dispute were reduced/denied by the respondent with the following reason code(s):
   - P12-Workers compensation jurisdictional fee schedule adjustment.

- 309-The charge for this procedure exceeds the fee schedule allowance.
- W3-Additional payment on appeal/reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 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

Is the requestor due reimbursement for code 99456-W5-MI (X2)?

Findings

On February 15, 2018, the claimant attended a Designated Doctor evaluation to determine MMI/IR and Extent of Injury. The requestor billed the respondent $3,370.00 for the evaluation. The respondent issued payment of $850.00 ($350.00 MMI and $500.00 for extent of injury) based upon the fee guideline. The issue in dispute is whether the requestor is due additional reimbursement of $100.00 for code 99456-W5-MI (X2).

The respondent contends that additional reimbursement is not due because "Requestor did not assign an impairment rating because the Claimant was found not to be at MMI. Therefore, no impairment rating could be assigned."

28 Texas Administrative Code §134.250(4)(B) states, "When multiple IRs are required as a component of a designated doctor examination under this title, the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code."

A review of the submitted report indicates the claimant had not reached MMI; therefore, an impairment rating was not calculated. The division finds the respondent's denial of payment is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that 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	Medical Fee Dispute Resolution Officer	7/11/2018 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, effective May 31, 2012, *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 MDR 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.