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
MELBURN K. HUEBNER, MD

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-19-1581-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
NOVEMBER 19, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have received your EOB and we are requesting that you reconsider the reduction that was taken. You paid on Code 99456 for the MMI which is $350.00 but did not pay on the modifier WP for the impairment rating which is $300.00."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 18, 2018	CPT Code 99456-WP Doctor Selected by Treating Doctor Maximum Medical Improvement/Impairment Rating (MMI/IR) Examination	$300.00	$300.00

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, effective May 31, 2012 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.210, effective July 7, 2016, provides the medical fee guideline for division specific services.
3. 28 Texas Administrative Code §134.250, effective July 7, 2016, sets the reimbursement guidelines for Maximum Medical Improvement Evaluations and Impairment Rating Examinations.

4. The services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
5. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on November 27, 2018. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

Is the requestor due additional reimbursement of $300.00 for code 99456-WP?

Findings

1. On June 18, 2018, the claimant attended a Doctor Selected by Treating Doctor examination to determine MMI/IR. The requestor billed the respondent $650.00 for the MMI/IR evaluation with CPT code 99456-WP. The respondent issued payment of $350.00 based upon the fee guideline. The issue in dispute is whether the requestor is due additional reimbursement of $300.00.

2. The requestor reported the following findings on the Designated Doctor Examination report:
   - MMI on 6/18/2018
   - Right Upper Extremity 3% IR

3. To determine the appropriate reimbursement the division refers to the following statutes:

   - 28 Texas Administrative Code §134.250(4)(C)(iii) states, "If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier 'WP.' Reimbursement shall be 100 percent of the total MAR."

   - 28 Texas Administrative Code §134.250(3)(C) states, "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."

   - 28 Texas Administrative Code §134.250 (4)(C)(i)(I)(II) states, "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)."

   - 28 Texas Administrative Code §134.250 (4)(C)(ii) states, "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 fourth 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."

   The Division reviewed the submitted documentation and finds the following:

   - The requestor billed 99456-WP for the MMI/IR.
   - Per 28 Texas Administrative Code §134.250(3)(C) the appropriate reimbursement for the MMI evaluation is $350.00.
   - The report indicates the requestor billed $300.00 for the right upper extremity impairment rating; therefore, the MAR is $300.00 per 28 Texas Administrative Code §134.250 (4)(C)(ii)(II)(a).
   - Total for IR is $300.00

- The total due for the MMI/IR is $650.00. The respondent paid $350.00. The requestor is due the difference between MAR and paid of $300.00**.**

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $300.00.

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 involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		04/04/2019
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, 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.