



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
BENJAMIN BURRIS, MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-19-2104-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
DECEMBER 11, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance with TDI-DWC Rule 133 and 134."

Amount in Dispute: \$800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The rationale given by the requestor for the late bill is not consistent with the Rule above. No payment is due."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 21, 2018, CPT Code 99456-WP (X2) Certifying Doctor Examination, \$800.00, \$800.00

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. Neither party to the dispute submitted any explanation of benefits to support the denial of payment.

Issues

Is the requestor due a reimbursement of \$800.00 for code 99456-WP(X2)?

Findings

1. The requestor is seeking reimbursement of \$800.00 for code 99456-WP(X2).

A review of the submitted documentation finds neither party to the dispute submitted any explanation of benefits to support the denial of payment was based upon timely filing of the bill.

The respondent wrote, "The rationale given by the requestor for the late bill is not consistent with the Rule above. No payment is due."

28 Texas Administrative Code §133.307(d)(2)(F) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review. If the response includes unresolved issues of compensability, extent of injury, liability, or medical necessity, the request for MFDR will be dismissed in accordance with subsection (f)(3)(B) or (C) of this section."

Because the respondent did not support the denial reasons were presented to the requestor prior to the date the request for MFDR, the division will not consider the defense raised any further. The division finds the disputed services will be reviewed per applicable Division rules and guidelines.

2. On July 21, 2018, the claimant attended a Certifying doctor examination to determine MMI/IR.

The requestor reported the following findings on the Certifying Doctor Examination report:

- Clinically MMI on 06-13-2018
- Lumbar Spine: 0%IR
- Sacral: 0% IR
- Left Hip: 0% IR

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 (X2) for the MMI/IR in accordance with 28 Texas Administrative Code §134.250(3) and (4).
- Per 28 Texas Administrative Code §134.250(3)(C) the appropriate reimbursement for the MMI evaluation is \$350.00.

- The report indicates the requestor performed ROM testing on the Spine and Pelvis; therefore, the total reimbursement is \$450.00 per 28 Texas Administrative Code §134.250 (4)(C)(ii)(II)(a).
- The total due for the MMI/IR is \$800.00. The respondent paid \$0.00. The requestor is due the difference between MAR and paid of \$800.00.

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 \$800.00.

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 \$800.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	2/7/2019 Date
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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.