



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

JKB MEDICAL EXAMS

Respondent Name

GREAT MIDWEST INSURANCE CO

MFDR Tracking Number

M4-19-2637-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

JANUARY 14, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed Great Midwest Insurance a total of \$950.00...but were paid \$800.00...We requested payment in the amount of \$150.00 as Dr. Bales determined an Impairment Rating for three body parts, which is a total of \$600.00. We were paid the complete \$350.00 for the MMI, but only \$450.00 of the total \$600.00 for the IR."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the provider is entitled to \$350.00 for the MMI portion of the exam and \$450.00 for the impairment rating portion of the exam pursuant to Division rule 134.250. The provider is not entitled to any additional reimbursement."

Response Submitted By: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: June 19, 2018, CPT Code 99456-W5-WP (X3) Designated Doctor Examination, \$150.00, \$150.00

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 §134.235, effective July 7, 2016, sets the reimbursement guidelines for return to work evaluations.
4. 28 Texas Administrative Code §134.240, effective July 7, 2016, sets the reimbursement guidelines for Designated Doctor Examinations.
5. 28 Texas Administrative Code §134.250, effective July 7, 2016, sets the reimbursement guidelines for Maximum Medical Improvement Evaluations and Impairment Rating Examinations.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - P12-Workers' compensation jurisdictional fee schedule adjustment.
 - 309-The charge for this procedure exceeds the fee schedule allowance.
 - 4150-An allowance has been paid for Designated Doctor Examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury.

Issues

Is the requestor due additional reimbursement of \$150.00 for code 99456-W5-WP(X3)?

Findings

1. On June 19, 2018, the claimant attended a Designated Doctor Examination to determine MMI/IR. The requestor billed the respondent \$950.00 for the MMI/IR evaluation with CPT code 99456-WP (X3). The respondent issued payment of \$800.00 based upon the fee guideline. The issue in dispute is whether the requestor is due additional reimbursement of \$150.00.
2. The DWC 32 noted examination of "Spine and Torso," "Upper Extremities," and "Other Body Areas or Systems". Box # 37 of this report lists the following compensable diagnoses: "Unspecified injury of head (S09.90XD); Unspecified open wound of unspecified part of head (S01.90XD); Strain of unspecified muscle, fascia and tendon at shoulder and upper arm level, RIGHT arm (S46.911D); Strain of muscle, fascia and tendon at neck level (S16.1XXD); Sprain of ligaments of thoracic spine (S23.3XXD); Sprain of ribs (S23.41XD); Abrasion of LEFT elbow (S50.312D)."
3. The requestor reported the following findings on the Designated Doctor Examination report:
 - MMI on May 9, 2018
 - CervicoThoracic 0% Whole Person Impairment
 - Right Upper Extremity 0%Whole Person Impairment
 - Head 0%Whole Person Impairment
 - Ribs/Chest 0%Whole Person Impairment

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-III) 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."

- 28 Texas Administrative Code §134.250 (4)(D)(i)(I)(II) states, “The following applies for billing and reimbursement of an IR evaluation. (D) Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR. (i) Non-musculoskeletal body areas are defined as follows: (I) body systems; (II) body structures (including skin); and (III) mental and behavioral disorders.”
- 28 Texas Administrative Code §134.250 (4)(D)(v) states, “The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.”

The Division reviewed the submitted documentation and finds the following:

- Per the DWC-32, the division ordered MMI/IR of 2 musculoskeletal and 1 non-musculoskeletal body areas.
- The requestor billed 99456-WP (X3) 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 performed ROM testing on the Upper Extremity and DRE testing of the Spine (CervicoThoracic, and Ribs); therefore, the MAR is \$450.00 per 28 Texas Administrative Code §134.250 (4)(C)(ii)(II)(a) and (b).
- Per 28 Texas Administrative Code §134.250 (4)(D)(v) the MAR for IR of 1 non-musculoskeletal areas (head) = \$150.00.
- Total for IR is \$600.00.
- The total due for the MMI/IR is \$950.00. The respondent paid \$800.00. The requestor is due the difference between MAR and paid of \$150.00.

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 \$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 involved in this 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

Signature	Medical Fee Dispute Resolution Officer	2/21/2019 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.