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
VALDEZ, DANIEL CONDE

Respondent Name
TASB RISK MGMT FUND

MFDR Tracking Number
M4-21-1605-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 10, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Maximum Allowable Reimbursement (MAR) for a MMI / IR examination is equal to the reimbursement for the MMI evaluation plus the reimbursement for the body area(s) evaluated for assignment of an IR … Reimbursement is $300 for the first musculoskeletal body area in which range of motioin is measured."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Only one WP reimbursed for 99456 per Exam, because multiple Exam of W5-WP can't be reimbursed at the same visit. The provider billed two 99456-WP with different charges."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 12, 2021	Examination to Determine Maximum Medical Improvement and Impairment Rating (99456-WP)	$300.00	$300.00

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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 308 – MMI/IR procedure code 99456 is permitted only once on the same date of service
   - 50 – These are non-covered services because this is not deemed a medical necessity by the payer

- 193 – Original payment decision is being maintained upon review, it was determined that this claim was processed properly.
- 282 – The insurance company is reducing or denying payment after reconsidering a bill.
- 351 – No additional reimbursement allowed after review of appeal/reconsideration.
- 375 – Please see special *note* below
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- Notes: "Only one WP reimbursed per Exam of WP can't be reimbursed at the same visit"
- Notes: "ALLOWED ONCE SAME DOS"

Issues

1. Is the examination in question subject to dismissal based on medical necessity?
2. Is Daniel C. Valdez, M.D. entitled to additional reimbursement for the examination in question?

Findings

1. Dr. Valdez is seeking reimbursement for determination of impairment rating performed in addition to an examination to determine maximum medical improvement. An examination to determine maximum medical improvement and impairment rating is necessary to determine the injured employee's entitlement to impairment income benefits,[1] therefore it is not subject to denial based on medical necessity. The insurance carrier's denial for this reason is not supported.
2. The examining doctor is required to bill an examination to determine maximum medical improvement with CPT code 99456.[2] The submitted documentation supports that Dr. Valdez performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

   The examining doctor is required to bill an examination to determine the impairment rating of an injury with CPT code 99456.[3] The submitted documentation supports that Dr. Valdez provided an impairment rating of the left knee with range of motion. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[4]

   The total allowable reimbursement for these examinations is $650.00. The insurance carrier paid $350.00. An additional reimbursement of $300.00 is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered. For the reasons stated above, the Texas Department of Insurance, Division of Workers' Compensation (DWC) finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $300.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

[1] Texas Labor Code §408.121
[2] 28 TAC §§134.250 (3)(C)
[3] 28 TAC §134.250 (4)(A)
[4] 28 TAC §134.250 (4)(C)(ii)(II)(-a-)

Authorized Signature

		June 25, 2021
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 Rule §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the DWC 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. **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.