



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

OCCUPATIONAL HEALTH RESOURCES INT'L
1015 WEST LOOP 281 STE 9
LONGVIEW TX 75604

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-3241-01

MFDR Date Received

June 28, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed is all documentation for [injured worker] exam by Dr. Stetzner on 03-26-2012. First ... this exam was requested by TDI/Ombudman – Pat Alcantar. Secon... Dr. Stetzner has the current CPT Code Descriptions/Instructions and the report does not lack information. Please read the enclosed report of the exam. Third... \$650.00 is according to the TDI Guidelines We are resubmitting the bill along with all documentation again for payment."

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor performed designated doctor services on the disputed date by determining maximum medical improvement (MMI) and impairment. The date of injury is [REDACTED]. The statutory MMI date is 10/29/10. However, the requestor declared the claimant reached statutory MMI on 5/19/11. Texas Mutual believes the requestor's DWC-69 is invalid for this reason."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 26, 2012	CPT Code 99456-WP	\$650.00	\$650.00

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

- 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, 37 Texas Register 3833, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
- 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services

on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated May 02, 2012

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION
- 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL GUIDELINES INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS

Explanation of benefits dated June 12, 2012

- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
- 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
- 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS

Issues

1. Were the services billed in accordance with 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Review of the submitted documentation provided by the requestor finds a DWC-69 Report of Medical Evaluation. In further review of the Report of Medical Evaluation (RME) finds the injured worker reached Maximum Medical Improvement (MMI) on June 12, 2011 as documented, the requestor addressed Maximum Medical Improvement (MMI) and Impairment Rating (IR) one to one body area being performed using range of motion (ROM) method. The requestor billed disputed service with CPT Code 99456-WP. Reimbursement is in accordance with 28 Texas Administrative Code §134.204 which states “(j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows. (3) The following applies for billing and reimbursement of an MMI evaluation. (B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has. (ii) not previously treated the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(C) of this subsection. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350. (4) The following applies for billing and reimbursement of an IR evaluation. (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form. (ii) The MAR for musculoskeletal body areas shall be as follows. (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area. The total reimbursement for CPT Code 99456-WP is \$650.00.
2. The respondent issued payment in the amount of \$0.00. Based upon the documentation submitted, additional reimbursement in the amount of \$650.00 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

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 \$650.00 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

March 28, 2014
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.