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

NADEEM MAHLI, MD
3100 TIMMONS LANE #250
HOUSTON, TX 77027

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-13-0155-01

MFDR Date Received

September 18, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I AM WIRITING IN REGARDS TO THIS INJURED WORKERS DESIGNATED DOCTORS CLAIM. PER YOUR EOB, IT STATES THAT THIS PROVIDER WAS NOT CERTIFIED FOR THE DATE OF SERVICE. PLEASE SEE THE ATTACHED CERTIFICATE SHOWING THAT THE PROVIDER WAS RECERTIFIED TO PERFORM DESIGNATED DOCTORS EXAM ON THIS DATE OF SERVICE. AT THIS TIME, I AM REQUESTING THAT THIS CLAIM BE REVIEWED ONCE AGAIN AND PLACED IN LINE FOR REIMBURSEMENT."

Amount in Dispute: $1,365.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual Insurance Company received a TWCC-60 from the above-mentioned requester. Pursuant to Commission Rule 133.307(d) Texas Mutual files the attached, completed response, and related items. The following is the carrier's statement with respect to this dispute. The Requestor performed designated doctor exams of the claimant on 4/16/12 then billed Texas Mutual codes 99456W5WP, 99456W8, 99456MI, and 9908073RR. Review of Tx Comp, Health Care Provider Detail, shows the requestor was not certified to perform the exams until 4/17/12. (Attachment) Further, the DWC-73 is incomplete in that boxes 4 and 21 are blank. For these reasons no payment is due for the billing."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
APRIL 16, 2012	CPT Code 99456 and 99080	$1,365.00	$0.00

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 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.

2. 28 Texas Administrative Code §130.1 sets out the guidelines for Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment.
3. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 24, 2012

   - CAC-B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service
   - CAC-W1 – Workers Compensation State Fee Schedule Adjustment
   - 249 – DWC-73 not submitted; not properly completed and/or missing doctors signature; reimbursement denied per rule 129.5
   - 304 – MMI or IR Certification is not valid for this date of service

   Explanation of benefits dated July 17, 2012

   - CAC-B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service
   - CAC-W1 – Workers Compensation State Fee Schedule Adjustment
   - CAC-193 – Original payment decision is being maintained, upon review, it was determined that this claim was processed properly
   - 249 – DWC-73 not submitted, not properly completed and/or missing doctors signature; reimbursement denied per Rule 129.5
   - 304 – MMI or IR certification is not valid for this date of service
   - 724 – No additional payment after a reconsideration services for information call 1-800-937-6824

Issues

1. What are the guidelines for a health care provider to certify Maximum Medical Improvement and Evaluation of Permanent Impairment?
2. Does the requestor's documentation support disputed service as billed?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §130.1 states in pertinent parts, "(a) Authorized Doctor. (1) Only an authorized doctor may certify maximum medical improvement (MMI), determine whether there is permanent impairment, and assign an impairment rating if there is permanent impairment. (A) Doctors serving in the following roles may be authorized as provided in subsection (a)(1)(B) of this section, (ii) a designated doctor; or …(B) Prior to September 1, 2003 a doctor serving in one of the roles described in subsection (a)(1)(A) of this subsection is authorized to determine whether an injured employee has permanent impairment, assign an impairment rating, and certify MMI. On or after September 1, 2003, a doctor serving in one of the roles described in subsection (a)(1)(A) of this section is authorized as follows: (i) a doctor whom the commission has certified to assign impairment ratings or otherwise given specific permission by exception to, is authorized to determine whether an injured employee has permanent impairment, assign an impairment rating, and certify MMI; and (ii) a doctor whom the commission has not certified to assign impairment ratings or otherwise given specific permission by exception to is only authorized to determine whether an injured employee has permanent impairment and, in the event that the injured employee has no impairment, certify MMI. (2) Doctors who are not authorized shall not make findings of permanent impairment, certify MMI, or assign impairment ratings and shall not be reimbursed for the examination, certification, or report if one does so. A certification of MMI, finding of permanent impairment, and/or impairment rating assigned by an unauthorized doctor are invalid. If a treating doctor finds that the injured employee has permanent impairment but is not authorized to assign an impairment rating, the doctor is also not authorized to certify MMI and shall refer the injured employee to a doctor who is so authorized.
2. Review of the requestor's documentation finds a copy of the requestor's Report of Medical Evaluation form (DWC 069). DWC-69 form indicates in Section II (Doctor's Role) box 13 that the doctor performing the exam is the Designated Doctor. The requestor also checked letter b in Section IV box 17 (Permanent impairment) certifying that the employee has permanent impairment as a result of the compensable injury. The amount of permanent impairment is 9 %.
3. A review of the Division's records finds that the health care provider is not authorized by the Division to assign Maximum Medical Improvement (MMI) and Impairment Ratings (IR). Therefore, in accordance with 130.1(a)

(2) reimbursement is not recommended.

Conclusion

For the reasons stated above, the division finds that no additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		1/3/14
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.