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

BENZEL C MACMASTER MD
8220 WALNUT HILL LN SUITE 310
DALLAS TX 75231

Respondent Name
HARTFORD INSURANCE COMPANY OF

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-13-0711-01

MFDR Date Received
November 14, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed please find DWC-60 listing the disputed charge for subject claim and date of service. Total disputed amount is $300.00

Also enclosed are copies of the medical bill as originally submitted and the explanation of benefits for that submission. Also attached are two requests for reconsideration and two explanation of bill review from the carrier …

We are requesting an additional $300.00 be paid for this bill, and that the carrier be given instructions regarding requests for reconsideration."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No response received from the carrier.

Response Submitted by: na

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14, 2012	CPT Code 99455V4WP	$300.00	$300.00

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§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 September 18, 2012

   - W1 – WORKERS COMPENSTION STATE FEE SCHEDULE ADJUSTMENT
   - QA – THE AMOUNT ADJUSTED IS DUE TO BUNDLING OR UNBUDNLING OF SERVICES

   Explanation of benefits dated October 12, 2012
   - 18 – DUPLICATE/CLAIM/SERVICE
   - QA – THE AMOUNT ADJUSTED IS DUE TO BUNDLING OR UNBUDLING OF SERVICES

   Explanation of benefits dated November 02, 2012
   - B13 – PREVIOUSLY PAID. PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT
   - PI – THESE ARE ADJUSTMENTS INITIATED BY THE PAYER, FOR SUCH REASONS AS BILLING ERRORS OR SERVICES THAT ARE CONSIDERED NOT REASONABLE OR NECESARRY. THE AMOUNT ADJUSTED IS GENERALLY NOT THE PATIENTS RESPONSIBILITY, UNLESS THE WORKERS COMPENSATION STATE LAW ALLWS THE PATIENT TO BE BILLED

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. Requestor billed with CPT Code 99455-V4-WP in the amount of $555.00 with one unit. Per the submitted documentation the services billed are for a Maximum Medical Improvement (MMI) and Impairment Rating (IR) examination.

   Per 28 Texas Administrative Code §134.204 states: (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows, (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include, (C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection, (3) The following applies for billing and reimbursement of an MMI evaluation, (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier, (i) Reimbursement shall be the applicable established patient office visit level associated with the examination, (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit, (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, (C) 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), (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; and (iii) 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.

   Therefore, CPT Code 99455-V4-WP is supported as the documentation does support that a request for Maximum Medical Improvement (MMI) and Impairment Rating (IR) was requested to address the issues with one body area being performed using Range of Motion (ROM) method.

2. The respondent issued payment in the amount of $169.06. Based upon the documentation submitted, additional reimbursement in the amount of $300.00 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 $300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March 07, 2014
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.