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

FONDREN ORTHOPEDIC GROUP
7401 S MAIN
HOUSTON TX 77030

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-1071-01

MFDR Date Received
January 02, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I write to express my objections with regards to your suggested fee reduction in reference to the services rendered on 7-7-10 to the above mentioned patient. We are in receipt of a payment of $113.85 on a $650.00 claim.

According to your audit on code 99455-V3-26, your listed reason of payment, identified as Explanation Code states, "W1-workers compensation state fee schedule. However this is incorrect as we are entitled to $300 for the initial body part and then $113.86 for the same level of office visit performed dentified by Modifier V3. Due to the fact that we billed 26 professional component the total amount would be paid at 80%."

Amount in Dispute: $217.74

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: This is a medical fee dispute concerning service date August 22, 2012. The service were an impairment rating evaluation. The Requestor billed a total of $650.00. Carrier has issued reimbursement in the amount of $113.85. Carrier is reviewing the bill and re-auditing it for potential reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2012	CPT Code 99455-V3-26	$217.74	$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§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 October 16, 2012

   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT

   Explanation of benefits dated November 15, 2012

   - B13 – PREVIOUSLY PAID, PAYMENT FOR THIS CLAIM/SERVICE MAY HAVE BEEN PROVIDED IN A PREVIOUS PAYMENT

Issues

1. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Review of submitted documentation finds a DWC-32 Report of Medical Evaluation by the treating doctor of K Matthew Warnock which in the report indicates the treating doctor performed impairment rating using range of motion (ROM). The provider billed with CPT Code 99455-V3-26. Per 28 Texas Administrative Code 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, (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. Reimbursement allowable for Maximum Medical Improvement (MMI) examination is $113.85. Per 28 Texas Administrative Code states "(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." Documentation supports that Impairment Rating (IR) examination was done by the treating doctor using range of motion (ROM) method, which the total allowable reimbursement for the impairment rating (IR) examination is $300.00. CPT Code 99456-V3-26 is not supported as per 28 Texas Administrative Code §134.204 states " (iv) If, in accordance with §130.1 of this title (relating to Certification of Maximum Medical Improvement and Evaluation of Permanent Impairment), the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80 percent of the total MAR" documentation does not support that the examining doctor did not perform the range of motion testing. No additional reimbursement is allowed.

2. The respondent issued payment in the amount of $0. Based upon the documentation submitted, no additional reimbursement is 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

		March 17, 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.