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

STEVEN DOORES
3523 MCKINNEY AVE #610
DALLAS TX 75204

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-13-1275-01

MFDR Date Received
January 22, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was submitted via fax 9/14/2012 with improper payment followed by Request for Reconsideration 10/24/2012 with no additional payment.

Claimant was seen for MMI and IR. IE had a lower extremity injury. The injury was disputed by the parties. Therefore, multiple impairments were submitted as required by statute and billed at $50. Payment for multiple IRs was denied."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "However, when the requestor billed Texas Mutual the bill listed codes 99456-W5-WP, 99456-W8-RE, and 99456-MI. Texas Mutual paid the MMI, IR and RTW exams yet the requestor also billed $50 for multiple impairments (MI). Because this was not requested on the EES-14 Texas Mutual declined to issue payment. The requestor state in this report, "… Claimant/providers allege that labral tear is part of the compensable injury. Therefore, multiple impairments are rendered."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 06, 2012	CPT Code 99456-MI	$50.00	$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§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 22, 2012

   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINES INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS

   Explanation of benefits dated November 21, 2012

   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 724 – NO ADDITIONAL PAYEMNT 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 CPT CODE DESCRPTIONS/INSTRUCTIONS

Issues

1. Is CPT Code 99456-MI supported?
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 is a EES-14 indicating Maximum Medical Improvement (MMI), Impairment Rating (IR) and Return to Work examinations which are selected for the purpose of the examinations requested and scheduled, DWC-69 Report of Medical Evaluation and the Designated Doctor Examination Report which indicates Maximum Medical Improvement (MMI), Impairment Rating (IR) and Return to Work (RTW) to be addressed. In further review of the Designated Doctor Examination the treating doctor notes that the purpose of the examination is to address Maximum Medical Improvement (MMI), Impairment Rating (IR) and return to work with two body areas being rated using the range of motion (ROM) method. However the examining doctor billed with CPT Code 99456-W5-WP with one unit (not in dispute), CPT Code 99456-W8-RE with one unit (not in dispute) and CPT Code 99456-MI (in dispute) in the amount of $50.00 with one unit. Reimbursement for the services are in accordance Per 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, (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, (B) When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code."

   Per above CPT Code 99456-MI is not supported as documentation shows that two body areas rated using range motion however review of medical bills provided document one unit billed for CPT Code 99456-W5-WP, CPT Code 99456-W8-RE and CPT Code 99456-MI. Therefore, CPT Code 99456-MI is not reimbursable in accordance with 28 Texas Administrative Code §134.204.

2. The respondent issued payment in the amount of $650.00. 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.