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

R EDWARD ROYBAL
PO BOX 741865
DALLAS TX 75374

Respondent Name
ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-13-1693-01

MFDR Date Received
March 05, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "**(F) a position statement of the disputed issue(s) that shall include:**

(i) **a descritption of the health care for which payment is in dispute,** Designated Doctor Exam

(ii) **the requestor's reasoning for why the disputed fees should be paid or refunded,**

CARRIER IS REQUIREDTO PAY DESIGNATED DOCTOR EXAMS."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No insurance carrier response

Response Submitted by: n/a

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 07, 2012	CPT Code 99456-WP-W5	$150.00	$150.00

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 November 16, 2012

- W1 – WORKERS' COMPENSATION JURISIDICATION FEE SCHEDULE ADJUSTMENT

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 submitted documentation (Designated Doctor Report) provided by the requestor indicates a Maximum Medical Improvement (MMI) and Impairment Rating (IR) examination was addressed with two body areas using range of motion (ROM) method. Requestor billed with CPT Code 99456-WP-W5. Reimbursement for disputed services of impairment rating are 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. (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. (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 (-b-) $150 for each additional musculoskeletal body area. CPT Code 99456-WP-W5 is supported additional reimbursement for the second body part rated using range of motion is allowed. The total Mar for CPT Code 99456-WP-W5 is $800.00.

2. The respondent issued payment in the amount of $650.00. Based upon the documentation submitted, additional reimbursement in the amount of $150.00 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 $150.00 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.