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
Nathaniel Greenwood, DO

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-0757-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
October 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to TEXAS MUTUAL INSURANCE on 10/23/2014, this request was in response to a $150.00 reducation of the $650.00 for the DESIGNATED DR EXAM performed on 07/12/2014. Unfortunately our request was denied and we are seeking the balance owed to us.

The denial reason(s) per EOB are: Workers Compensation fee schedule adjustment. Designated Doctor Exams are billed according to DWC rule 134.204 and in accordance with labor code 408.004, 408.0041, and 408.151.

…Range of motion was necessary and performed as part of a full evaluation for the billed examination…

The rule indicates 'if a full physical evaluation WITH RANGE OF MOTION IS PERFORMED the MAR shall be $300.00 for the first musculoskeletal body area and $150.00 for each additional musculoskeletal body area.

Therefore, per the original report submitted with this claim, you will note a 'full physical evaluation with range of motion was performed' and was included in the explanation of the impairment rating in the report…"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of **7/12/2014**. The requester billed one unit of 99456-W5/WP. Texas Mutual paid $350.00 for the MMI exam. Texas Mutual paid $150.00 for the first non-musculoskeletal area assessed for impairment, the ribs. Texas Mutual did not pay any other non-musculoskeletal areas assessed because of only the one unit billed."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 12, 2014	Designated Doctor Examination	$150.00	$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 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the procedures for billing and reimbursing Designated Doctor Examinations.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - CAC-P12 – Workers' Compensation jurisdictional fee schedule adjustment.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

1. What is the correct MAR for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. Therefore, the correct MAR for this examination is $350.00.

   This dispute involves a Designated Doctor Impairment Rating (IR) evaluation, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4), which states that, "(D) …(i) Non-musculoskeletal body areas are defined as follows: (I) **body systems**; (II) body structures (including skin); and, (III) mental and behavioral disorders. (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides… (v) **The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150**" [emphasis added]. Review of the submitted documentation finds that the requestor performed impairment rating evaluations of the ribs, left hemi-diaphragm and hemithorax, abdomen, and liver. The AMA Guides to the Evaluation of Permanent Impairment (fourth edition) places the ribs and diaphragm in the respiratory **system**, and the abdomen and liver in the digestive **system**. For this reason, they all fall into the body system subsection in the non-musculoskeletal category. While a full physical examination with range of motion was performed on the thoracic spine, this was not a requested body area for the examination, nor was an impairment rating provided for the spine. Therefore, the correct MAR for the examination to determine Impairment Rating is $150.00.
2. The Division finds that the correct reimbursement for the disputed services is $500.00. The insurance carrier paid $500.00. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

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

	Laurie Garnes	January 21, 2015
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.