



## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### General Information

**Requestor Name**

Melburn Huebner, M.D.

**Respondent Name**

Crestbrook Insurance Co.

**MFDR Tracking Number**

M4-24-1986-01

**Carrier's Austin Representative**

Box Number 6

**DWC Date Received**

May 13, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 3, 2024	99456-WP	\$150.00	\$150.00
<b>Total</b>		<b>\$150.00</b>	<b>\$150.00</b>

### Requestor's Position

"Please review as it is my understanding that TDIWC ruling 134.201, \$300.00 is reimbursed for the first body part for the impairment and \$300.00 is reimbursed for placing the client at MMI."

**Amount in Dispute:** \$150.00

### Respondent's Position

"Carrier's bill review company properly calculated reimbursement in this case and therefore, the Carrier stands by the payment amount set forth in the EOBs."

**Response Submitted by:** Stone Laughlin & Swanson, LLP

## Findings and Decision

### Authority

This medical fee dispute is decided according to [Texas Labor Code §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.250](#) sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

### Adjustment Reasons

The insurance carrier denied or reduced the payment for the disputed services with the following claim adjustment codes:

- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAD BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

### Issues

1. What rules apply to the service in dispute?
2. Is the requestor entitled to additional reimbursement?

### Findings

1. This medical fee dispute involves an examination for the purpose of establishing: if maximum medical improvement (MMI) has been reached; what date MMI was reached if applicable; and to provide impairment ratings (IR) if MMI has been reached.

On the disputed date of service, the requestor billed \$650.00 for CPT code 99456-WP. CPT code 99456 indicates the service of a maximum medical improvement (MMI) and/or impairment rating (IR) examination by a doctor other than the treating doctor. Modifier WP indicates that the same examining doctor performed the MMI examination and the IR testing of the musculoskeletal body area(s), thus reimbursement shall be 100 percent of the total maximum allowable reimbursement (MAR).

DWC finds that 28 TAC §134.250 applies to the reimbursement of the service in dispute. 28 TAC §134.250, which sets out the fee guidelines for maximum medical improvement examinations and impairment ratings, states in pertinent part, "(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. (4) The following applies for

billing and reimbursement of an IR evaluation. (A) The health care provider 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 unit's 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 maximum allowable reimbursement (MAR) for musculoskeletal body areas shall be as follows:

- (I) \$150 for each body area if the diagnosis related estimates (DRE) method found in the AMA Guides fourth edition is used.
- (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.

(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..."

2. The requestor is seeking additional reimbursement in the amount of \$150.00 for an examination to determine maximum medical improvement and impairment rating.

The submitted documentation supports that on the disputed date of service, the requestor performed an evaluation of maximum medical improvement (MMI). Per 28 TAC §134.250 (3)(C), the maximum allowable reimbursement (MAR) for this examination is \$350.00.

A review of the submitted documentation finds that on the same disputed date of service, the requestor performed an impairment rating (IR) evaluation of the upper extremity, one musculoskeletal body area, with range of motion performed. The rule at 28 TAC §134.250 (4)(C)(ii) defines the fees for the calculation of an impairment rating for musculoskeletal body areas. The MAR for the evaluation of the first musculoskeletal body area performed with range of motion is \$300.00. The MAR for the evaluation of subsequent musculoskeletal body areas is \$150.00 each. The requestor assigned an impairment rating utilizing range of motion for the upper extremity, one musculoskeletal body area. The total allowable reimbursement for the impairment rating of the musculoskeletal body area for this dispute is \$300.00.

In accordance with 28 TAC §134.250, the reimbursements which apply to the disputed examination rendered on April 3, 2024, are:

- For an MMI examination, reimbursement is \$350.00.
- For an IR of one musculoskeletal body area with range of motion measurements, reimbursement is \$300.00.
- DWC finds that the total maximum allowable reimbursement for the examination in question rendered on April 3, 2024, is \$650.00.
- Per explanation of benefits submitted, the insurance carrier paid \$500.00 for the disputed services.
- Additional reimbursement in the amount of \$150.00 is recommended.

DWC finds that additional reimbursement in the amount of \$150.00 is due for the services in dispute.

### Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has established that additional reimbursement in the amount of \$150.00 is due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$150.00 additional reimbursement for the disputed services. It is ordered that Crestbrook Insurance Co., must remit to Melburn Huebner, M.D. \$150.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### **Authorized Signature**

June 5, 2024

\_\_\_\_\_  
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiera hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).