Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Downtown Performance Rehabilitation 3033 Fannin Houston, TX 77004	MFDR Tracking #: M4-05-5503-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Texas Mutual Insurance Co. Box # 54	Date of Injury: Employer Name: Crown Staffing Inc. Insurance Carrier #: 99D0000339585

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary:

"No response to request for reconsideration from carrier, partially paid impairment rating."

Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary:

"(CPT Code 99455-V3) and a bill for $300.00 that was partially paid by the carrier, leaving $232.75 in dispute. The carrier moves to abate or dismiss this dispute until the provider shows that a timely request for reconsideration was made."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 77004 is located in Harris county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
8-10-04	Z560	99455-V3-WP	1-6	$232.75
Total Due:				

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, sets out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "The charge for this procedure exceeds the fee schedule or usual and customary allowance."

2. Per Rule 133.307(e)(2)(b), the Requestor submitted convincing evidence (a letter requesting reconsideration of bill and a facsimile transmission report) of carrier's receipt of the Requestor's request for an EOB; therefore, the disputed service will be reviewed in accordance with the Division's *Medical Fee Guideline.*

3. 99455-V3-WP:

   - DWC Rule 134.202(e)(6)(c)(i)(I)(II) states in part: (c) The following applies for billing and reimbursement of an MMI evaluation. (i) An examining doctor who is the treating doctor shall bill using the 'Work related or medical disability examination by the treating physician…" CPT code 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."

4. The Requestor is the treating doctor; therefore, the examination was coded correctly using CPT code 99455. Per Rule 134.202(e)(6)(c)(i)(I)(II), the modifier –V3 refers to the applicable office visit. CPT code 99213's MAR is $67.25. Thus, the appropriate reimbursement for the evaluation with modifier-V3 is $67.25.

5. According to Rule 134.202(e)(6)(D)(II), "The MAR for musculoskeletal body areas shall be as follows.
   a) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th Edition is used.
   b) If full physical evaluation, with range of motion is performed:
      1) $300 for the first musculoskeletal body area; and
      2) $150 for each additional musculoskeletal body area.

6. The Requestor documented a DRE method to determine impairment rating; thus, the appropriate reimbursement for evaluation of two body areas is $300.00. This amount plus the MMI evaluation of $67.25 equals $367.25. The Respondent paid $67.25 leaving a balance of $367.25. The Requestor noted that the amount in dispute is $232.75. Per Rule 134.202(d), "reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge." The Requestor is due $232.75.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $232.75 plus accrued interest, due within 30 days of receipt of this Order.

ORDER / DECISION:

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
	Elizabeth Pickle, RHIA	June 20, 2007

PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. §413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision, that is the subject of the appeal, is final and appealable. The Division is not considered a party to the appeal.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.