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: Victor I. Lyday, MD 1303 McCullough, #361 San Antonio, TX 78212	MFDR Tracking #: M4-05-6814-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Old Republic Insurance Co. Box #02	Date of Injury: Employer Name: Levi Strauss & Co. Insurance Carrier #: 35961356521317

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary:

"We billed the correct dollar amount for MMI/IR and correct CPT Code. However, our initial claim was processed wrong. Total reimbursement for MMI/IR is $650.00 for either treating or non-treating MMI/IR. The auditors allowed only $247.40."

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:

"The bill was rec'd for DOS 01/21/05 by the carrier on 01/27/05. A pymt was issued to the provider on 03/07/05 amt $247.40 based on CPT code submitted on HCFA."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 78212 is located in Bexar county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
1-21-05	F	99455-V4-WP	1-4	$0.00
Total Due:				$0.00

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 " F-Reduction according to medical fee guidelines."

2. 99455-V4-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."

3. 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 –V4 refers to the applicable office visit. CPT code 99214's MAR is $97.40. Thus, the appropriate reimbursement for the evaluation with modifier-V4 is $97.40.

- 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.

4. The Requestor documented a DRE method to determine impairment rating; thus, the appropriate reimbursement for evaluation of one body area is $150.00. This amount plus the MMI evaluation of $97.40 equals $247.40. The insurance carrier paid $247.40; therefore, the Requestor is not due additional reimbursement.

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

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 not entitled to additional reimbursement for the services involved in this dispute.

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.