



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Nestor Martinez, DC 6660 Airline Dr. Houston, TX 77076	MFDR Tracking #: M4-07-4260-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: Texas Mutual Insurance Co. Box # 54	Date of Injury:
	Employer Name: On Our Own Services Inc.
	Insurance Carrier #: 99G0000448208

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary:

None submitted.

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:

"Texas Mutual paid for the one body that is the basis of the compensable injury, the lower left leg."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
10-20-06	W1, 790, W4, 891	99455-V3-WP	1-4	\$0.00
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 "W1 – Workers Compensation State Fee Schedule Adjustment; 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline; W4 – No additional reimbursement allowed after review of appeal/reconsideration; and 891 – The insurance company is reducing or denying payment after reconsideration."
2. 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."

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 -V3 refers to the applicable office visit. CPT code 99213's MAR in Harris County is \$67.20. Thus, the appropriate reimbursement for the evaluation with modifier-V3 is \$67.20.
 - 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 lower extremity DRE-method is \$150.00. This amount plus the MMI evaluation of \$67.20 equals \$217.20. The insurance carrier paid \$367.24; 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 reimbursement for the services involved in this dispute.

DECISION:

Elizabeth Pickle, RHIA

June 21, 2007

Authorized Signature

Medical Fee Dispute Resolution Officer

Date

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.