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: Western Medical Evaluators 1302 Teasley Lane Denton, TX 76205	MFDR Tracking #: M4-07-4752-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: Texas Mutual Insurance Co. Box #54	Date of Injury: Employer Name: Cude Oilfield Contractors Insurance Carrier #: 99F0000432911

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary:

"We billed for 2 units and per TDI rules allows us an additional $300.00."

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 audited the bill, reviewed the report, concluding that one area, the lumbar was rated."

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 75234 is located in Dallas county.

Date(s) of Service	Denial Code(s)	CPT Code(s) and Calculations	Part V Reference	Amount Due
5-8-06	W4, 18, 878, 891, 42, 790	99456-WP Evaluation for MMI/IR	1-7	$150.00
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 "W4 – No additional reimbursement allowed after review of appeal/reconsideration; 18 – Duplicate claim/service; 878 – Duplicate appeal request medical dispute resolution through DWC for continued disagreement of original appeal decision; 891 – The insurance company is reducing or denying payment after reconsideration; 42 – Charges exceed our fee schedule or maximum allowable amount; 790 – This charge was reduced in accordance to the Texas Medical Fee Guideline; and The insurance company is reducing or denying payment after reconsideration."

2. The disputed service is not a duplicate service billed on same date, it is a duplicate bill that was submitted to the insurance carrier for reconsideration.

3. According to Rule 134.202(e)(6)(C)(iii), "An examining doctor, other than the treating doctor, shall bill using the 'Work related or medical disability examination by other than the treating physician….' CPT code. Reimbursement shall be $350."

4. 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.

5. According to Rule 134.202(e)(6)(D)(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 the modifier "WP." Reimbursement shall be 100% of the total MAR."

6. Advisory 2004-01, issued on March 25, 2004, stated in part that, "an IR by the DRE method or injury model, this type of IR is reimbursed at $150 per DRE area. Both of the above fees are reimbursed in addition to the $350 paid for the MMI evaluation."

7. On this date, the Requestor billed $1,000.00 for CPT code 99456-WP. Per Advisory 2004-01, The Requestor correctly coded the MMI and IR evaluation using CPT code 99456-WP. Per Rule 134.202(e)(6)(C)(iii), the Requestor is entitled to reimbursement of $350.00 for MMI evaluation. In addition, Rule 134.202(e)(6)(D)(II)(b) allows reimbursement of $300.00 for IR-ROM method for the first musculoskeletal body area. Therefore, the Requestor is entitled to reimbursement of $650.00. The insurance carrier paid $500.00. The Requestor is entitled to the difference between amount paid and due, which equals $150.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202
Advisory 2004-01

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 $150.00 plus accrued interest, due within 30 days of receipt of this Order.

ORDER :

Authorized Signature	Medical Fee Dispute Resolution Officer	Date
	Elizabeth Pickle, RHIA	May 31, 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.