**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:<br>Western Medical Evaluators<br>1302 Teasley Lane<br>Denton, TX 76205 | MFDR Tracking #: M4-07-5626-01<br>DWC Claim #:<br>Injured Employee: |
| Respondent Name and Box #:<br>Texas Mutual Insurance Co.<br>Box #54 | Date of Injury:<br>Employer Name: Masterwork International Inc.<br>Insurance Carrier #: 99E0000368524 |

## PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary:

"Per TDI Rule 134.202 exam to pay $350.00 1st unit to pay $300.00 with ROM 2nd and 3rd units to pay $150.00 each."

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's payment of $350.00 for MMI evaluation and $300.00 for Range of Motion (ROM) method is in accordance with DWC Rule 134.202."

Principle Documentation:

1. DWC 60 package

## PART IV: SUMMARY OF FINDINGS

Review of the box 32 on CMS-1500, revealed zip code 77479 is located in Fort Bend county.

| Date(s) of Service | Denial Code(s) | CPT Code(s) and Calculations | Part V Reference | Amount Due |
|---|---|---|---|---|
| 1-12-07 | W1, 790, 891, W4 | 99456-WP Evaluation for MMI/IR | 1-6 | $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. 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."

3. 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. 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."

5. 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."

6. On this date, the Requestor billed $1,200.00 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 and $150.00 for additional area. Based upon the IR report the spine and upper extremity was tested. Therefore, the Requestor is entitled to reimbursement of $800.00. The insurance carrier paid $800.00. The Requestor is not entitled to 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
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 not entitled to reimbursement for the services involved in this dispute.

**DECISION:**

| | Elizabeth Pickle, RHIA | May 31, 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.**