Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
DR. WAYNE A. SOIGNIER

Respondent Name
FIDELITY & GUARANTY INSURANCE

MFDR Tracking Number
M4-13-1608-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
FEBRUARY 26, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "per Medical Fee Guidelines."

Amount in Dispute: $125.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed $1750 for the evaluation and asserts he is entitled to reimbursement in the amount of $650. The carrier has previously reimbursed the requestor $525 for the examination, leaving a deficit of $125. The carrier is going to re-process the disputed medical bill, and tender the additional recommended reimbursement amount to the requestor."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 6, 2012	CPT Code 99456-W5-WP Designated Doctor Evaluation	$125.00	$125.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1-Workers compensation state fee schedule adjustment.
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - 851-The allowance was adjusted in accordance with multiple procedure rules and/or guidelines.
   - 193-Original payment decision is being maintained. This claim was processed properly the first time.
   - 1014-The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Did the Designated Doctor bill for the MMI/IR evaluation in accordance with medical fee guideline?
2. Is the requestor entitled to reimbursement?

Findings

1. On the disputed date of service the requestor billed CPT code 99456-W5-WP.

   - 28 Texas Administrative Code §134.204(i)(1)(A) states "The following shall apply to Designated Doctor Examinations. (1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows: (A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor"

   A review of the submitted medical billing finds that the requestor billed modifier "W5" as the first modifier appended to CPT code 99456.

   - 28 Texas Administrative Code §134.204(j)(3) states "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350."

   The requestor billed CPT code 99456 because the examination was performed by a designated doctor.

   - 28 Texas Administrative Code §134.204(j)(4)(C)(iii) states "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 modifier "WP." Reimbursement shall be 100 percent of the total MAR."

   - 28 Texas Administrative Code §134.204(n)(18) states "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. The "WP" modifier is defined as "Whole Procedure--This modifier shall be added to the CPT code when both the professional and technical components of a procedure are performed by a single HCP."

   A review of the requestor's billing finds that the "WP" modifier was appended to CPT code 99456 to designate that the provider had performed the MMI examination and the IR testing. The Division finds that the requestor billed for the MMI/IR in accordance with 28 Texas Administrative Code §134.204(j).

2. The maximum allowable reimbursement (MAR) for CPT code 99456-W5-WP is:

   - 28 Texas Administrative Code §134.204(j)(1) states "Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:
     (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR."
   - 28 Texas Administrative Code §134.204(j)(4)(C) states "For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas."
   - 28 Texas Administrative Code §134.204(j)(4)(C)(ii) states "The MAR for musculoskeletal body areas shall be as follows.
     (II) If full physical evaluation, with range of motion, is performed:
     (-a-) $300 for the first musculoskeletal body area."

   The requestor billed for MMI/IR of one body areas. A review of the Designated Doctor report finds that a full evaluation with range of motion was performed on the left wrist; therefore, the MAR is $300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). The total allowable for the impairment rating is $300.00 and $350.00 for the MMI evaluation.

   The Division finds that the total allowable for the MMI/IR evaluation is $650.00. The respondent paid $525.00. As a result, the requestor is entitled to reimbursement of $125.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $125.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $125.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		10/20/2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

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