



**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](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

MARSHALL SACK, MD

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-14-2000-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

MARCH 7, 2014

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "Designated Doctor Examinations are billed according to DWC Rule 134.204 and in accordance with Labor Code 408.004, 408.0041, and 408.151."

**Amount in Dispute:** \$650.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The requestor performed MMI and IR exams for the treating doctor and then billed Texas Mutual code 99456W5WP. Texas Mutual denied payment absent correct coding for the exams."

**Response Submitted by:** Texas Mutual Insurance Co.

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 19, 2013	CPT Code 99456-W5-WP	\$650.00	\$650.00

**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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - W5-W9 modifiers are reserved for Designated Doctors only.
  - CAC-W3, 350-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.
  - CAC-W1-Workers compensation state fee schedule adjustment.
  - CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
  - 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

- 724-No additional payment after a reconsideration of services.
- 732-Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

### Issues

1. Does the documentation support billing?
2. Is the requestor entitled to reimbursement?

### Findings

1. On the disputed date of service the requestor billed CPT code 99456-W5-WP. According to the MMI/IR report the claimant was referred to the requestor by the treating doctor for the examination. The respondent contends that "The requestor performed MMI and IR exams for the treating doctor and then billed Texas Mutual code 99456W5WP. Texas Mutual denied payment absent correct coding for the exams."

- 28 Texas Administrative Code §134.204(j)(3)(B) states "If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has:
  - (i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this subsection; or,
  - (ii) not previously treated the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(C) of this subsection"

A review of the submitted documentation does not support that the referral doctor had previously treated the injured employee; therefore, 28 Texas Administrative Code §134.204(j)(3)(B)(ii) applies to the medical billing for the exam.

- 28 Texas Administrative Code §134.204(j)(3)(C) states "The following applies for billing and reimbursement of an MMI evaluation. 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 doctor other than the treating 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.

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.

(I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

(II) If full physical evaluation, with range of motion, is performed:

(-a-) \$300 for the first musculoskeletal body area; and

(-b-) \$150 for each additional musculoskeletal body area.”

A review of the Designated Doctor report finds that a full evaluation with range of motion was performed on the right and left shoulder; therefore, the MAR is \$300.00 for the IR per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) and \$350.00 for the MMI evaluation per 28 Texas Administrative Code §134.204(j)(3)(C), for a total allowable of \$650.00. The respondent paid \$00.00. As a result, the requestor is entitled to reimbursement of \$650.00.

### **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 \$650.00.

### ***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 \$650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

11/19/2014  
\_\_\_\_\_  
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.**