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
J. THOMAS DILGER JR, MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-0140-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
SEPTEMBER 12, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a Designated Doctor Examination performed on 11/26/12."

Amount in Dispute: $850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 26, 2012	CPT Code 99456-W5-NM Designated Doctor Examination for MMI/IR	$350.00	$350.00
	CPT Code 99456-RE-W8 Designated Doctor Examination for Return to Work	$500.00	$500.00
TOTAL		$850.00	$850.00

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. Neither party to this dispute submitted copies of the explanation of benefits to support denial/reduction of payment for the disputed services.

The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on September 20, 2013. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the

requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Did the Designated Doctor bill for the MMI examination in accordance with medical fee guideline?
2. Is the requestor entitled to reimbursement?
3. Did the Designated Doctor bill for the Return to Work examinations in accordance with medical fee guideline?
4. Is the requestor entitled to reimbursement?

Findings

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

   - 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 appended modifier "W5" 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.

   - Per 28 Texas Administrative Code §134.204(j) "Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: (A) If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added."

   - 28 Texas Administrative Code §134.204(n)(6) 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 "NM" modifier is defined as "Not at Maximum Medical Improvement (MMI)--This modifier shall be added to the appropriate MMI CPT code to indicate that the injured employee has not reached MMI when the purpose of the examination was to determine MMI."

   A review of the requestor's billing finds that the "NM" modifier was appended to CPT code 99456 to designate that the claimant had not reached MMI.

   The Division finds that the Designated Doctor billed for the evaluation/examination in accordance with 28 Texas Administrative Code §134.204; therefore, reimbursement is recommended.

2. 28 Texas Administrative Code §134.204(j)(3) indicates that the total maximum allowable reimbursement, (MAR), for CPT code 99456-W5-NM is $350.00. The respondent paid $0.00. As a result, the requestor is entitled to reimbursement of $350.00.
3. On the disputed date of service, the requestor also billed CPT code 99456-RE-W8.

   - 28 Texas Administrative Code §134.204(i)(1)(E) indicates that modifier "W8" is billed for examination that determine the "Ability of the employee to return to work shall be billed and reimbursed in accordance with subsection (k) of this section."

A review of the submitted medical billing finds that the requestor supported billing 99456-RE-W8.

4. The MAR for CPT code 99456-RE-W8 is:

- 28 Texas Administrative Code §134.204(k) states "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

The requestor is due $500.00 for the Return to Work examination. The respondent paid $0.00. As a result, the requestor is entitled to reimbursement of $500.00.

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 $850.00.

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 $850.00 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	12/19/2014 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.