



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

GERALD T. DELK, MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-0164-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

SEPTEMBER 16, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Aaron Allison, Esq...referred [Claimant] for medical evaluation for alternate MMI and impairment evaluations and for determination of the extent of injury."

Amount in Dispute: \$500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual paid the MMI exam. However, Texas Mutual could not find no record the treating doctor wanted to establish the extent of injury. Further, the requestor in the introduction of his exam stated 'I have been asked by the injured employee's treating physician to perform a certified medical evaluation on the injured employee for the determination of maximum medical improvement and/or impairment rating assessment. It was explained to the claimant prior to the evaluation that the purpose of this examination was for evaluation only'...What is more, the requestor's DWC-60 packet contains no evidence to support that an extent of injury exam was intended with the referral by the treating doctor. No additional payment due. "

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 18, 2012	Designated Doctor Examination for MMI/IR CPT Code 99456-W5-NM	\$0.00	\$0.00
	Designated Doctor Examination for Extent of Injury CPT Code 99456-W6-RE	\$500.00	\$0.00
TOTAL		\$500.00	\$0.00

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.

3. 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-W1-Workers compensation state fee schedule adjustment.
 - 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
 - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 724-No additional payment after a reconsideration of services.
 - CAC-18-Duplicate claim/service.

Issues

Does the submitted documentation support that the extent of injury examination was performed in accordance with the fee guideline? Is the requestor entitled to reimbursement for CPT code 99456-W6-RE?

Findings

On the disputed date of service the requestor billed CPT codes 99456-W6-RE and 99456-W5-NM. (The respondent paid for the MMI/IR evaluation and is not in dispute)

- 28 Texas Administrative Code §134.204(i)(1)(C) 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: (C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier ‘W6;’”
- 28 Texas Administrative Code §134.204(n)(21) defines the “W6” modifier as “Designated Doctor Examination for Extent--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining extent of the employee's compensable injury.”

A review of the submitted medical billing finds that the requestor appended modifier “W6” to CPT code 99456 in accordance with 28 Texas Administrative Code §134.204(i)(1)(C).

- 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 respondent contends that reimbursement was denied because “Texas Mutual could not find no record the treating doctor wanted to establish the extent of injury.” The requestor did not submit any documentation to support who requested the extent of injury examination; therefore, no reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

11/05/2014
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.