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. DAVID TAYLOR

Respondent Name
INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number
M4-14-0893-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
NOVEMBER 19, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a claim for [Claimant]…on January 11, 2013. Enclosed are a copy of the original fax cover sheet and a copy of 1500 claim form, DWC069 form and Dr. Taylor's examination notes."

Amount in Dispute: $650.00

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
January 3, 2013	CPT Code 99456-WP Designated Doctor Evaluation	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
3. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.
4. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 29-The time limit for filing has expired.
   - 937-Services not timely filed by the provider.

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 November 27, 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. Does the documentation support the claim was filed timely?
2. Did the Designated Doctor bill for the MMI/IR evaluation in accordance with medical fee guideline?
3. Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for the disputed Designated Doctor Evaluation based upon reason code "29."

   Texas Labor Code §408.027(a) states "A health care provider shall submit a claim for payment to the insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment.'

   28 Texas Administrative Code §102.4(h), states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:
   (1) the date received, if sent by fax, personal delivery or electronic transmission or,
   (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

   The requestor submitted a copy of a fax confirmation report dated January 11, 2013 that supports bill was submitted timely in accordance with Texas Labor Code §408.027(a); therefore, reimbursement is recommended per applicable Division rules and guidelines.

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

   28 Texas Administrative Code §134.204(j)(3)(C) 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 Designated Doctor billed for the evaluation/examination in accordance with 28 Texas Administrative Code §134.204; therefore, reimbursement is recommended.

3. The maximum allowable reimbursement (MAR) for CPT code 99456-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: 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 upper extremities and hands; therefore, the MAR is $300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a).

Per 28 Texas Administrative Code §134.204(j)(3)(C) the requestor is due $350.00 for the MMI evaluation.

The Division finds that the total allowable for the MMI/IR evaluation is $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	10/14/2014 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.