



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

MARCOS V. MASSON, MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-2144-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

MARCH 17, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We do not believe the denial is justified. We have billed based on the Texas department of workers compensation billing and reimbursement guidelines. This is an Impairment rating encounter and we billed CPT code 99455 with a modifier V5 to show the level of performance for treating doctors or other doctors who have previously treated the injured workers, and; WP to show for whole procedure."

Amount in Dispute: \$467.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed 99455-V5-WP for an MMI evaluation on the date above. The DWC-69 indicates the requestor was selected by the treating doctor to conduct the exam. Rule 134.204 at (j)(3)(C) states in part, 'An examining doctor, other than the treating doctor, shall bill using CPT Code 99456...' No payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 26, 2013	CPT Code 99455-V5-WP	\$467.80	\$467.80

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.
- 714--Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly. Corrections must be submitted w/ 95 days from the DOS.
- 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 99455-V5-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 billed 99455-V5-WP for an MMI evaluation on the date above. The DWC-69 indicates the requestor was selected by the treating doctor to conduct the exam. Rule 134.204 at (j)(3)(C) states in part, 'An examining doctor, other than the treating doctor, shall bill using CPT Code 99456...' No payment is due."
 - 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 supports that the referral doctor had previously treated the injured employee; therefore, 28 Texas Administrative Code §134.204(j)(3)(B)(i) applies to the medical billing for the exam.

28 Texas Administrative Code §134.204(j)(3)(A) states "(A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier. (i) Reimbursement shall be the applicable established patient office visit level associated with the examination. (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit."

The requestor billed CPT code 99455-V5 because the examination was performed by a doctor that had previously treated the patient.

- 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 99455 to designate that the provider had performed the MMI examination and the IR testing.

2. The requestor appended the "V5" modifier to CPT code 99455; therefore, the applicable corresponding office visit CPT code is 99215.

- Per 28 Texas Administrative Code §134.203(c)(1)(2), “To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
 (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is \$52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is \$66.32.
 (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year’s conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year’s conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007.”

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

- The 2013 DWC conversion factor for this service is 55.30.
- The Medicare Conversion Factor is 34.023.
- Review of Box 32 on the CMS-1500 the services were rendered in zip code 75702 in Houston, Texas. Per Medicare the provider is reimbursed using the locality of “Houston, Texas.”
- The Medicare Participating amount for code 99215 is \$143.31.

Using the above formula, the Division finds the total allowable for the MMI evaluation is \$232.93.

- 28 Texas Administrative Code §134.204(j)(4) states “The following applies for billing and reimbursement of an IR evaluation. (A) The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.
 (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet).”

The requestor evaluated the claimant’s right arm; therefore, one body area was evaluated.

- 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.”

The requestor documented a full examination with range of motion; therefore, the requestor is due \$300.00 for the IR examination.

- The Division finds that the total allowable for the MMI/IR is \$532.93. The requestor is seeking \$467.80. The respondent paid \$0.00. As a result, \$467.80 is recommended in reimbursement.

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 \$467.80.

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 \$467.80 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.