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
Katasha E. Lindley-Perry, MD

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-15-0997-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
November 24, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We submitted a request for reconsideration to TEXAS MUTUAL on July 28, 2014, this request was in response to a $650.00 nonpayment of the $650.00 for the Designated Doctor Exam performed on January 23, 2014. Unfortunately our request was denied and we are seeking the balance owed to us.

The denial reason(s) per EOB are: Workers Compensation fee schedule adjustment. Designated Doctor Exams 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 following is the carrier's statement with respect to this dispute of 1/23/14. The requestor, as designated doctor, concluded the claimant was not at MMI and then billed Texas Mutual code 99456-W5/WP. Texas Mutual denied the billing for incorrect coding because the documentation stated the claimant was not at MMI. No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 23, 2014	Designated Doctor Examination	$650.00	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Designated Doctor Examinations.
3. 28 Texas Administrative Code §133.20 sets out the procedures for medical bill submission by a health care provider.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 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.
   - 732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed.
   - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT Code description/instructions.
   - CAC-P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment.
   - 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. For information call 1-800-937-6824.

Issues

1. Did the requestor bill the disputed services according to 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (i)(1) states, in pertinent part, "Designated Doctors shall perform examinations … 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; (B) **Attainment of maximum medical improvement** 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" [emphasis added]. A review of the submitted documentation finds that the designated doctor found the injured employee had **not** attained maximum medical improvement, so could not be assigned an impairment rating. Therefore, the modifier "W5" is not supported.

   Further, 28 Texas Administrative Code §134.204 (j)(4)(C)(iii) states, in pertinent part, "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**'…" [emphasis added]. As no impairment rating was performed, the modifier "WP" is not supported.

   Additionally, 28 Texas Administrative Code §134.204 (j)(2)(A) states, "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**" [emphasis added]. As the submitted report states that the injured employee had not reached maximum medical improvement, the modifier "NM" was required.

   The Division finds that the requestor did not bill the disputed services according to 28 Texas Administrative Code §134.204.
2. 28 Texas Administrative Code §133.20 (c) states, "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills." Therefore, the requestor is not entitled to reimbursement for the disputed services.

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	January 29, 2015 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.