



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Stephen Carter, MD

**Respondent Name**

Service Lloyds Insurance Company

**MFDR Tracking Number**

M4-15-2301-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

March 24, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "We submitted a request for reconsideration to Service Lloyds on 12-30/14, this request was in response to a \$150.00 reeducation of the \$1450.00 for the DDE performed on 8-27-2014. 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:** \$150.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "...Upon notification of this complaint CorVel performed an in-depth review of the circumstances surrounding the medical billing processed for complainant, Stephen A. Carter, MD, date of service 08/27/2014 in the amount of \$1450.00. Based on review of all submitted medical billing, the designated doctor report and report of medical evaluations labeled 'compensable only and compensable with non-compensable,' CorVel determined that an overpayment in the amount of \$150.00 for CPT code 99456 (-W5,-WP) was incorrectly issued to the complainant for an impairment rating (IR) to the cervical musculoskeletal body area found not to be at Maximum Medical Improvement (MMI).

**Audit Rationale:**

DOS	DWC069 DX	CPT Code	Mod	Units	TAC Requirement Applied	Amt. Billed	Amount Paid
8/27/2014	840.9	99456	W5, WP	3	\$134.204 (i)(I)(A-B) & (j)(4)(C)(ii)(II)	\$950.00	\$800.00
8/27/2014	840.9	99456	W6, RE	1	\$134.204(i)(I)(C) & (k)	\$500.00	\$500.00
Total Amount						\$1,450.00	\$1,300.00
Compliance Review Findings						Overpayment	\$150.00

Pursuant to §134.204. Medical Fee Guideline for Workers' Compensation Specific Services.

(i) 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;

- (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;
- (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;'

Rule §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. Subsection (3)(C) goes on to states an examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.

Per the Request for Designated Doctor Examination (DWC032) and Commission Order, the complainant was designated to determine MMI, IR and Extent of Injury. When an MMI/IR examination and one or more non-MMI/IR examinations are required under the same Division order, the MMI/IR examination is calculated separately and is reimbursed in addition to the non-MMI/IR examinations. For example:

**Compensable Only (DWC069)**

**§134.204(j)(4)(C)(ii)(II)**

	<b>Paid</b>	<b>Body Area/Comment</b>
- MMI	\$350	
- IR 1st body area ROM	\$300	<b>*Left Shoulder-correct</b>
- 2nd body area	\$150	<b>*Cervical – error/not at MMI IR portion not payable</b>

**§134.204(i)(1)(C)&(k)**

- Extent of injury	\$500	<b>*Return to Work not addressed</b>
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**Compensable with Non-Compensable (DWC069)**

To date the complainant has not submitted medical billing nor evidence to substantiate a claim for additional reimbursement pursuant to the Act or division rules for services addressing non-compensable musculoskeletal body areas. Given no violation of the Workers' Compensation Act or Commission Rules or policies, CorVel respectfully requests this referral be dismissed and an order of refund issued to the complainant for the IR overpayment of \$150.00 for the cervical musculoskeletal body area found not to be at MMI."

**Response Submitted by:** CorVel

***SUMMARY OF FINDINGS***

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 27, 2014	Designated Doctor Examination (MMI/IR/EOI)	\$150.00	\$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 Designate Doctor Examinations.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - ORC – MMI/IR at ROM method for 2 areas
  - P12 – Workers' Compensation State Fee Schedule Adj
  - ORC – MMI/IR at ROM method for 2 areas only – spine & upper extremities/hands. MMI eval + IR/ROM
  - 168 – No additional allowance recommended
  - B13 – Payment for service may have been previously paid

**Issues**

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. Per 28 Texas Administrative Code §134.204 (j)(3), "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 submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement (MMI) as ordered by the Division. Therefore, the correct MAR for this examination is \$350.00.

Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for **billing and reimbursement of an IR evaluation**. (C)(ii) 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" [emphasis added]. The submitted documentation indicates that the Designated Doctor performed a full physical evaluation with range of motion for the left shoulder to find the Impairment Rating. While documentation finds that other body areas were examined, no Impairment Ratings were given for these areas, as they were found not to be at MMI. Therefore, the correct MAR for this examination is \$300.00.

Per 28 Texas Administrative Code §134.204 (k), "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 submitted documentation indicates that the Designated Doctor performed an examination to determine Extent of Injury. Therefore, the correct MAR for this examination is \$500.00.

2. The total allowable for the disputed services is \$1150.00. The insurance carrier paid \$1300.00. Therefore, no additional 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**

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Signature

Laurie Garnes  
Medical Fee Dispute Resolution Officer

April 28, 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.**