



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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### AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

LINDA MILLER, MD

**Respondent Name**

FEDEX GROUND PACKAGE SYSTEM INC

**MFDR Tracking Number**

M4-16-0375

**Carrier's Austin Representative**

Box Number 22

**MFDR Date Received**

OCTOBER 13, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "On 10/30/13 I performed a Designated Doctor Examination on [Claimant] for the purposes of addressing maximum medical improvement (MMI), impairment rating, and extent of injury. The exam...was assigned to me as noted in the enclosed Commissioner Order."

**Amount in Dispute:** \$550.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** The respondent did not submit a response to the request for medical fee dispute resolution.

#### SUMMARY OF FINDINGS

| Dates of Service | Disputed Services   | Amount In Dispute | Amount Due |
|------------------|---|-------------------|------------|
| October 30, 2014 | CPT Code 99456-W6-RE<br>Extent of Injury Evaluation         | \$500.00          | \$500.00   |
|                  | CPT Code 99456-W5-MI<br>Liability/Compensability Evaluation | \$50.00           | \$0.00     |
| TOTAL            |   | \$550.00          | \$500.00   |

#### FINDINGS AND DECISION

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

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, 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:
  - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
  - D96-Denied-Non authorized service.
  - P12-Workers compensation jurisdictional fee schedule adjustment.
  - P13-Payment reduced ro denied based on workers' compensation jurisdictional regulations or payment policies. Use only if no other code is applicable.
4. 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 October 20, 2015. 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. Is the requestor entitled to reimbursement for 99456-RE-W6?
2. Does the documentation support billing code 99456-W5-MI? Is the requestor entitled to additional reimbursement?

## **Findings**

1. On the disputed date of service, the requestor billed CPT codes 99456-W5-WP, 99456-W6-RE and 99456-W5-MI. Code 99456-W5-WP was reimbursed \$650.00 and is not in dispute.

According to the submitted explanation of benefits, the respondent denied reimbursement for code 99456-W6-RE based upon reason code "D96."

A review of the *Commissioner Order* report finds that the Division requested a Designated Doctor examination to determine maximum medical improvement (MMI), impairment rating (IR), and Extent of Injury.

- 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."
- 28 Texas Administrative Code §134.204(i)(1)(C) stipulates, "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."

The Division finds that based upon the *Commissioner Order* the requestor was authorized to perform an extent of injury examination; therefore, the respondent's denial based upon reason code "D96" is not supported. As a result, reimbursement of \$500.00 is recommended.

2. According to the submitted explanation of benefits, the requestor paid \$50.00 for code 99456-MI (X2) based upon reason codes "885" and "P13." The issue in dispute is whether or not additional reimbursement of

\$50.00 is due for code 99456-MI.

- 28 Texas Administrative Code §134.204(j)(4)(B) states, "The following applies for billing and reimbursement of an IR evaluation: When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed \$50 for **each additional IR calculation** [emphasis added]. Modifier "MI" shall be added to the MMI evaluation CPT code."

The division finds that the narrative report and enclosed forms support that examinations to determine Maximum Medical Improvement, Impairment Rating, and Extent of Injury were performed, and **one** [emphasis added] additional impairment rating was provided. Therefore, the correct MAR for this service is \$50.00. The insurance carrier reimbursed this service at \$50.00. As a result, additional reimbursement is not recommended.

**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 \$500.00.

**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 \$500.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

|           |  |            |
|-----------|--|------------|
| _____     | Greg Arendt                            | 01/07/2016 |
| Signature | Medical Fee Dispute Resolution Officer | 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.**