TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Edward W. Smith, D.O.

Respondent Name
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-16-1785-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
February 26, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to Texas law the Fee Schedule reimbursement for an impairment rating performed that includes range of motion measurements is $300 in addition to the fee schedule $350 reimbursement for the determination of MMI status. Range of Motion measurements were taken and recorded for this examination and utilized in determining the appropriate impairment rating. The original claim form was properly coded and submitted in a timely fashion to the carrier."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the EOBs. The bill was reviewed … and denied 'One or more Diagnosis Code(s) is incomplete on the medical bill. Resubmit with complete diagnosis code per associated version'. The provider submitted new information and the bill was reconsidered… It was denied as 'The procedure code is inconsistent with the modifier used or a required modifier is missing'."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 20, 2015	Designated Doctor Examination	$650.00	$650.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 schedule for division-specific services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 14 – (146) Diagnosis was invalid for the date(s) of service reported.
   - 18 – (18) Duplicate claim/service.
   - 4 – (4) The procedure code is inconsistent with the modifier used or a required modifier is missing.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 14 – "(146) DIAGNOSIS WAS INVALID FOR THE DATE(S) OF SERVICE REPORTED." Review of the submitted documentation finds that the insurance carrier did not maintain this denial reason on the explanation of benefits dated February 15, 2016 or in their position statement.

   The insurance carrier denied disputed services with claim adjustment reason code 4 – "(4) THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING." 28 Texas Administrative Code §134.204(i)(B) states, "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."

   28 Texas Administrative Code §134.204(j)(3)(C) states that for the billing and reimbursement of an examination to determine maximum medical improvement (MMI), "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." Review of the submitted documentation finds that the requestor billed procedure code 99456 with modifier W5 for an examination to determine if the injured employee had reached MMI.

   28 Texas Administrative Code §134.204(i)(A) states, "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."

   28 Texas Administrative Code §134.204(j)(4)(C)(iii) states that for billing and reimbursement of an impairment rating (IR), "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." Review of the submitted documentation finds that the requestor billed procedure code 99456 with modifiers W5 and WP for the IR of a musculoskeletal body area.

   The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per the fee guidelines in 28 Texas Administrative Code §134.204.

2. Per 28 Texas Administrative Code §134.204(j)(3)(C), reimbursement for an examination to determine MMI is $350.00. For the determination of IR, 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II) states that, "If full physical evaluation, with range of motion, is performed: (-a) $300 for the first musculoskeletal body area …" Submitted documentation supports that the requestor performed an evaluation to determine MMI and a full physical evaluation, with range of motion, for the IR of the left knee. Therefore, the total MAR for the disputed services is $650.00.

3. The division finds that the total MAR for the disputed services is $650.00. The insurance carrier paid $0.00. A reimbursement of $650.00 is 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 $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 in 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

	Laurie Garnes	May 27, 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, 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 MFDR 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.