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
Patricia Olivares, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-2373-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
April 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "POST DESIGNATED DOCTOR EXAMINATION WORK COMP 'SPECIFIC SERVICE' NO PAYMENT RECEIVED TO DATE"

Amount in Dispute: $865.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Section 408.0041(h) of the Labor Code identifies when the carrier is required to pay for IR, MMI, extent of injury, disability, and return to work exams: (a) At the request of an insurance carrier or an employee, or on the commissioner's own order; (f) Unless otherwise ordered by the commissioner, the insurance carrier shall pay benefits based on the opinion of the designated doctor during the pendency of any dispute; and f-2) An employee required to be examined by a designated doctor may request a medical examination to determine maximum medical improvement.

None of these apply. The requester performed MMI/IR and return to work exams at the request of the treating doctor.

No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 23, 2015	Referral Doctor Examination to Determine Maximum Medical Improvement, Impairment Rating, and Return to Work Work Status Report	$865.00	$15.00

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 §129.5 sets out the procedures for filing Work Status Reports.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
4. Texas Labor Code §408.0041 sets out the requirements for designated doctor examinations.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 743 – MMI/IR has been determined by a designated doctor. Subsequent exams for MMI/IR not appropriate.
   - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
   - 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.

Issues

1. Is the insurance carrier's denial of payment supported?
2. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 892 – "DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS." The requestor is seeking reimbursement for the following procedure codes: 99456-NM, 99456-RE, and 99080-73, as indicated on the Medical Fee Dispute Resolution Request.

   For procedure code 99456-NM: Review of the submitted documentation does not find this code billed. However, documentation included a similar billed procedure code of 99456-NM-WP. Therefore, this is the code that will be reviewed for this dispute. 28 Texas Administrative Code §134.204(j)(3)(C) states, that the following applies for the billing and reimbursement of an MMI evaluation: "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." Further, 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.

   28 Texas Administrative Code §134.204(j)(4(C)(iii) states that the following applies for billing and reimbursement of an IR evaluation:

   > 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 information finds that the requestor performed an examination to determine MMI and found that the injured employee had not reached MMI. The documentation does not support that an IR evaluation was performed. Therefore, the insurance carrier's denial of procedure code 99456-NM-WP is supported. No reimbursement is recommended for this service.

   For procedure code 99456-RE: 28 Texas Administrative Code §134.204(k) states, in relevant part:

   > 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…"

   Review of the submitted documentation does not find that the examination to determine the injured employee's ability to return to work was requested by the division or the insurance carrier. Therefore, the

insurance carrier's denial of procedure code 99456-RE is supported. No reimbursement is recommended for this service.

For procedure code 99080-73: Billing and reimbursement for this code is established in 28 Texas Administrative Code §129.5(i), which states:

> Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be $15. A doctor shall not bill in excess of $15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows:
> (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section…

28 Texas Administrative Code §129.5(d)(1) states that a doctor shall file the Work Status Report "after the initial examination of the employee, regardless of the employee's work status." Therefore, the insurance carrier's denial for this reason is not supported.

The insurance carrier also denied procedure code 99080-73 with claim adjustment reason code 743 – "MMI/IR HAS BEEN DETERMINED BY A DESIGNATED DOCTOR. SUBSEQUENT EXAMS FOR MMI/IR NOT APPROPRIATE." Procedure code 99080-73 represents the billing of a Work Status Report. Because this is not an examination for MMI/IR, the insurance carrier's denial for this reason is not supported.

2. Because the insurance carrier's denials of payment for procedure code 99080-73 were not supported, the requestor is eligible for reimbursement of this code. In accordance with 28 Texas Administrative Code §129.5(i), the total reimbursement is $15.00. This is the amount 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 $15.00.

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 $15.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	June 10, 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.