



# 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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Jesse O. Schneringer, D.C.

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-17-2225-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

March 22, 2017

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "I submitted billing and records and an EOB was sent out denying payment stating that a 2<sup>nd</sup> modifier was missing. I resubmitted a request for reconsideration, with a letter from TDI-DWC indicating that a 2<sup>nd</sup> modifier is not required when the patient is at MMI, payment was denied a second time. Reimbursement should have been \$350.00 for determination of MMI. I was also asked to address extent of injury and I am required to give multiple impairments, there were 3 separate impairments calculated for \$50, one of them was not paid, therefore reimbursement should have been \$50; for a total of \$400."

**Amount in Dispute:** \$400.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requestor billed \$350.00 for code 99456-W5-NM. However, the narrative report indicated the claimant was at MMI and an IR was assigned. Texas Mutual denied payment indicating accurate coding is essential."

**Response Submitted by:** Texas Mutual Insurance Company

#### SUMMARY OF FINDINGS

| Dates of Service  | Disputed Services  | Amount In Dispute | Amount Due |
|-------------------|--|-------------------|------------|
| December 15, 2016 | Designated Doctor Examination (99456-W5-NM, 99456-W5-MI) | \$400.00          | \$0.00     |

#### 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 §134.210 provides the guidelines for division-specific services performed on or after September 1, 2016.

3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating performed on or after September 1, 2016.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
  - CAC-50 – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.
  - 308 – MMI/IR procedure code 99456 is permitted only once on the same date of service.
  - 732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed.
  - CAC-P12 – Workers’ compensation jurisdictional fee schedule adjustment.
  - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
  - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
  - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
  - 724 – No additional payment after a reconsideration of services.
  - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

### **Issues**

1. Is Jesse O. Schneringer, D.C. entitled to reimbursement for procedure code 99456-W5-NM?
2. Is Dr. Schneringer entitled to additional reimbursement for procedure code 99456-W5-MI?

### **Findings**

1. Dr. Schneringer is seeking reimbursement of \$350.00 for procedure code 99456-W5-NM. Texas Mutual Insurance Company (Texas Mutual) denied this service with claim adjustment reason codes CAC-4 – “THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING,” and 732 – “ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. MODIFIER BILLED INCORRECTLY OR MISSING. SERVICES ARE NOT REIMBURSABLE AS BILLED.”

28 Texas Administrative Code §134.250(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 section. Modifier ‘NM’ shall be added.”

28 Texas Administrative Code §134.210(e)(6) defines the “NM” modifier as “not at maximum medical improvement (MMI)--This modifier shall be added to the appropriate MMI CPT code to indicate that the injured employee has not reached MMI when the purpose of the examination was to determine MMI.”

Review of the submitted information finds that Dr. Schneringer did include a finding that the injured employee had reached MMI. The insurance carrier’s denial for this reason is supported. Additional reimbursement cannot be recommended for this service.

2. Dr. Schneringer is also seeking an additional \$50.00 for procedure code 99456-W5-MI. Review of submitted billing finds that Dr. Schneringer billed for a total of three units for this service. Texas Mutual stated in its position statement that it has “elected to pay code 99456-W5-MI.” Per Explanation of Benefits dated January 18, 2017, Texas Mutual reimbursed two units. Submitted evidence does not support that the third service in question has been paid to date. Therefore, this service will be reviewed as requested.

Per Explanation of Benefits dated February 14, 2017, Texas Mutual denied the service in question with claim adjustment reason code 225 – “THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.”

28 Texas Administrative Code §134.250(4)(B) states, “When multiple IRs are required as a component of a designated doctor examination under this title, the designated doctor shall bill for the number of body areas

rated and be reimbursed \$50 for **each additional** [emphasis added] IR calculation. Modifier 'MI' shall be added to the MMI evaluation CPT code.”

Submitted documentation finds that Dr. Schneringer provided a total of three impairment rating (IR) calculations. Per 28 Texas Administrative Code §134.250(1), the total reimbursement for MMI/IR examinations include the assignment of an IR. Therefore, only the **additional** calculations are eligible for reimbursement in accordance with 28 Texas Administrative Code §134.250(4)(B). The division concludes that Dr. Schneringer is not entitled to additional reimbursement for this service.

**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 additional reimbursement for the services in dispute.

**Authorized Signature**

|           |  |                            |
|-----------|--|----------------------------|
| _____     | _____ Laurie Garnes _____              | _____ April 17, 2017 _____ |
| 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.**