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
Jesse Schneringer, D.C.

Respondent Name
Hartford Underwriters Insurance Company

MFDR Tracking Number
M4-18-1379-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
January 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I was ordered to perform an evaluation for extent of injury. I am required to calculate multiple impairments for when extent of injury is in question. I calculated 3 different impairment ratings: for the compensable injury, for the disputed condition, and for the disputed/compensable injury."

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Reimbursement was issued in accordance with Rule 134.204 (j) (4) (C) (i) II)."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 14, 2017	Designated Doctor Examination (99456-MI x 2)	$100.00	$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 §134.240 sets out the fee guidelines for designated doctor examinations.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 256 – Billing of modifier is not appropriate for services performed.
   - W3 – Additional payment made on appeal/reconsideration.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Jesse Schneringer, D.C. is seeking additional reimbursement for multiple impairment ratings billed with a designated doctor examination performed on February 14, 2017. Hartford Underwriters Insurance Company (Hartford) denied the services in question with claim adjustment reason codes 4 – "THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING," and 256 – "BILLING OF MODIFIER IS NOT APPROPRIATE FOR SERVICES PERFORMED."

   Review of the submitted documents finds that the services in question were billing with procedure code 99456-W5-MI. When a designated doctor performs an examination for impairment, the service is billed with modifier "W5."[1] The division concludes that this modifier is not inconsistent with the services in question.

   If multiple impairment rating calculations are required, the service is billed with modifier "MI."[2] The division concludes that this modifier is appropriate for the services in question. Hartford's reason for denial of payment is not supported.

2. Because Hartford failed to support its denial of payment for the services in question, the division will review these services in accordance with applicable fee guidelines.

   When multiple impairment ratings are required, the designated doctor shall be reimbursed for each **additional calculation** of impairment.[2] The submitted documentation supports that Dr. Schneringer provided only one calculation of impairment with no additional calculations. No further 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	August 2, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §134.240(1)(A)
[2] 28 Texas Administrative Code §134.250(4)(B)

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 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. **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.