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
LAURENCE LIGON, MD

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-18-1649-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
JANUARY 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and in compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider billed $1,100.00 for 4 units CPT code 99456-WP. The Carrier reimbursed $800.00. The Provider apparently contends they are entitled to additional reimbursement of $300.00 for the additional units of CPT 99456-WP, however, despite copious documentation, they provide no rationale for why additional reimbursement is due…Consequently, the Carrier can only surmise that the Provider is arguing the impairment rating of the head and face conditions constituted additional body areas. When evaluating a head and face injury, one is evaluating an injury to body structures. This constitutes a non-musculoskeletal body area, as defined in Rule 134.250(4)(D)(i)(II). As such, Rule 134.250(4)(D) requires the Provider to bill the appropriate CPT code for the testing to that non-musculoskeletal body area when determining impairment. The Provider herein billed only CPT code 99456, and did not submit any other CPT codes on the billing for this date of service. Consequently, the Carrier properly calculated reimbursement for the MMI evaluation and the impairment rating of the lumbar spine and lower extremity (one DRE and one ROM musculoskeletal body area)…no additional reimbursement is due for this service."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 1, 2017	CPT Code 99456-WP (X4) Certifying Doctor Examination	$300.00	$0.00

FINDINGS AND DECISION

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 §134.210, effective July 7, 2016, provides the medical fee guideline for division specific services.
3. 28 Texas Administrative Code §134.235, effective July 7, 2016, sets the reimbursement guidelines for return to work evaluations.
4. 28 Texas Administrative Code §134.240, effective July 7, 2016, sets the reimbursement guidelines for Designated Doctor Examinations.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 863-Reimbursement is based on the applicable reimbursement fee schedule.
   - W3-Additional payment made on appeal/reconsideration.
   - 947-Upheld. No additional allowance has been recommended.

Issues

1. Did the Designated Doctor bill for the MMI/IR evaluation in accordance with medical fee guideline?
2. Is the requestor entitled to reimbursement for impairment rating of head and face?

Findings

1. On the disputed date of service the requestor billed $1,100.00 for CPT code 99456-WP. The respondent paid $800.00. The issue in dispute is whether the requestor is due additional reimbursement of $300.00.

   The respondent contends that reimbursement is not due because, "the documentation they do submit is substantially irrelevant to the issue presented on the DWC 60 Table of Disputed Services, which appears to be the proper calculation of the Maximum Allowable Reimbursement for the impairment rating evaluation. As such, documentation regarding functional capacity evaluations, preauthorization, proof of timely submission, and what appears to be the entirety of Chapter 133 and 134 related to medical billing rules is entirely irrelevant and wasteful of the Division's and Carrier's resources…Consequently, the Carrier can only surmise that the Provider is arguing the impairment rating of the head and face conditions constituted additional body areas. When evaluating a head and face injury, one is evaluating an injury to body structures. This constitutes a non musculoskeletal body area, as defined in Rule 134.250(4)(D)(i)(II). As such, Rule 134.250(4)(D) requires the Provider to bill the appropriate CPT code for the testing to that non-musculoskeletal body area when determining impairment. The Provider herein billed only CPT code 99456, and did not submit any other CPT codes on the billing for this date of service. Consequently, the Carrier properly calculated reimbursement for the MMI evaluation and the impairment rating of the lumbar spine and lower extremity…"

   28 Texas Administrative Code §134.210(b)(2) states, "Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, insurance carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, division-specific modifiers are identified in subsection (e) of this section. When two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill."

   28 Texas Administrative Code §134.240(1)(B) states, "Designated doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041, and 408.151 and division rules, and shall be billed and reimbursed as follows: (B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with §134.250 of this title, 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 §134.250(C) states "If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this section."

   The division finds the requestor did not append modifier "W5" as the first modifier to code 99456. To determine the appropriate reimbursement, billing must include the appropriate modifiers as outlined in 28 Texas Administrative Code §134.240. The division finds the requestor did not bill for the MMI/IR in accordance with the fee guideline.

2. The requestor is seeking additional reimbursement of $300.00 for an impairment rating to the head and skin/face.

   28 Texas Administrative Code §134.250(4)(D)(i) states, " Non-musculoskeletal body areas shall be billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR.

(i) Non-musculoskeletal body areas are defined as follows: (I) body systems; (II) body structures (including skin)."

The division finds the requestor did not bill for any CPT code(s) for the tests required for the assignment of IR to the head and skin/face in accordance with 28 Texas Administrative Code §134.250(4)(D)(i). The division reviewed the report and finds the requestor did not list any tests used for the assignment of IR to the head and skin/face.

28 Texas Administrative Code §134.250(4)(D)(iv) states, "When there is no test to determine an IR for a non-musculoskeletal condition: (I) The IR is based on the charts in the AMA Guides. These charts generally show a category of impairment and a range of percentage ratings that fall within that category. (II) The impairment rating doctor must determine and assign a finite whole percentage number rating from the range of percentage ratings. (III) Use of these charts to assign an IR is equivalent to assigning an IR by the DRE method as referenced in subparagraph (C)(ii)(I) of this paragraph.

A review of the submitted IR report finds the requestor did not indicate if the charts in the AMA Guides were used for the calculation of 0% IR of the head and skin/face.

The division finds the requestor has not supported what methodology or sufficiently documented the IR to face and head.

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 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	3/20/2018 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.