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
Jack P. Mitchell, D.C.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-18-3526-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 23, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DOS 02/08/20187, code 99456-WP-SP (2) units represents MMI/IR examination by a Designated Doctor. This commissioners order was specifically for a non-MMI/IR, specifically for extent of injury. Due to the issues of extent, additional testing was ordered, interpreted as well as incorporated into the final report submitted and properly billed. The-SP Modifier represents the incorporation of a specialists report. In this case there were 2 performed and incorporated."

Amount in Dispute: $100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester billed $100.00 for review of additional testing apparently bearing on extent of injury issue. Texas Mutual declined to issue payment as there is no provision in Rule 134.204, for extent of injury exams, to bill separately for review of such testing."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 8, 2018	Designated Doctor Examination (99456-WP-SP)	$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 §134.235 sets out the fee guidelines for reimbursement of extent of injury examinations.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for reimbursement of 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:
   - CAC-P12 – Workers' compensation jurisdiction fee schedule adjustment.
   - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217 – The value of this procedure is included in the value of another procedure performed on this date.
   - 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issues

Is Jack P. Mitchell, D.C. entitled to additional reimbursement for the disputed examination?

Findings

Dr. Mitchell is seeking reimbursement for incorporating reports of additional testing in association with a designated doctor examination to determine the extent of the compensable injury.

A designated doctor is eligible for reimbursement for the performance of additional testing required to answer the question ordered by the Texas Department of Insurance, Division of Workers' Compensation (DWC). The billing for these services are to be billed with the CPT codes appropriate to the tests performed.[1]

The requestor argued that "code 99456-WP-SP (2) units represents **MMI/IR examination** by a Designated Doctor. **This commissioners order was specifically for a non-MMI/IR**, specifically for extent of injury [emphasis added]." The DWC agrees that the billing code in question indicates "incorporating one or more specialists' report(s) information **into the final assignment of IR** [emphasis added]."[2]

The DWC finds that the designated doctor examination performed on February 8, 2018, did not include an assignment of impairment rating (IR). Therefore, billing code 99456-WP-SP does not apply to the examination in question. No additional reimbursement can be 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	September 24, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §134.235

[2] 28 Texas Administrative Code §134.250(4)(iii)(I)

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.