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
GILBERT MAYORGA, MD

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-18-3574-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
MAY 24, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…the patient was seen for a designated doctor evaluation. Total fees as allowed by the Texas Fee Guideline were in the amount of $350.00. However, we have not received payment from the carrier to date."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per the above all diagnosis code [redacted] is not a valid code."

Response Submitted By: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2017	CPT Code 99456-W5-NM Designated Doctor Evaluation	$350.00	$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, effective May 31, 2012, 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 §134.240, effective July 7, 2016, sets the reimbursement guidelines for Designated Doctor Examinations.
4. 28 Texas Administrative Code §134.250, effective July 7, 2016, sets the reimbursement guidelines for

Maximum Medical Improvement Evaluations and Impairment Rating Examinations.

5. 28 Texas Administrative Code §133.20, effective May 2, 2006, sets out the procedure for submitting medical bills by health care providers.
6. 28 Texas Administrative Code §133.240, effective March 30, 2014, sets out the procedures for medical bill processing by the insurance carriers.
7. The insurance carrier reduced payment for the disputed services without any claim adjustment codes.

Issues

Is the respondent's denial of payment for code 99456-W5-NM supported?

Findings

The requestor is seeking dispute resolution for CPT code 99456-W5-NM in the amount of $350.00. A review of the submitted explanation of benefits finds that the respondent did not list any claim adjustment codes to support the denial of payment. The respondent wrote in position summary that reimbursement was denied because "Per the above all diagnosis code [redacted] is not a valid code."

To determine if the respondent's denial of payment is supported, the division refers to the following statute:

- 28 Texas Administrative Code § 133.10(f)(1)(Q) and (R) states, "All information submitted on required paper billing forms must be legible and completed in accordance with this section. The parenthetical information following each term in this section refers to the applicable paper medical billing form and the field number corresponding to the medical billing form. (1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care:
  - (Q) procedure/modifier code (CMS-1500, field 24D) is required; and
  - (R) diagnosis pointer (CMS-1500, field 24E) is required."

- 28 Texas Administrative Code §133.20(c) requires "A health care provider shall include correct billing codes from the applicable Division fee guidelines in effect on the date(s) of service when submitting medical bills."

- 28 Texas Administrative Code §133.240(f)(17)(H) explanation of the reason for reduction/denial if the adjustment reason code was included under subparagraph (G) of this paragraph and if applicable."

- 28 Texas Administrative Code §134.240(1)(A)(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: (A) Impairment caused by the compensable injury 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; (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(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 §134.250(3)(C) states "The following applies for 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."

Based upon the above referenced statute and submitted documentation, the division finds:

- The respondent did not comply with 28 Texas Administrative Code §133.240(f)(17)(H) because reason adjustment codes were not listed on the explanation of benefits.
- The requestor incorrectly billed with the "W5" modifier because claimant was not at MMI or IR.
- The requestor did not use a valid ICD-10 code "[redacted]".
- The correct code for a designated doctor evaluation when MMI has not been reached is 99456-NM.
- The requestor is not due reimbursement because of the billing errors for the procedure and diagnosis.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due.

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

		9/21/2018
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, 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.