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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BRODERRICK D. KOOLMAN, DC

Respondent Name
XL SPECIALTY INSURANCE CO

MFDR Tracking Number
M4-18-3613-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MAY 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached CMS1500 is being billed for the Designated Doctor's exam and is not included in the bill for the FCE."

Amount in Dispute: $850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The review of the bill is complete and it has been determined that the provider is not due any additional monies."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2017	CPT Code 99456-W5-NM	$350.00	$350.00
	CPT Code 99456-W8-RE	$500.00	$500.00
TOTAL		$850.00	$850.00

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, sets out the reimbursement guidelines 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 §134.250, effective July 7, 2016, sets the policy billing and reimbursement guidelines for Maximum Medical Improvement (MMI) and/or Impairment Rating (IR) examinations..

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - W3-Request for reconsideration.
   - 193-Original payment decision is being maintained. Upon review, it was determined that his claimw as processed properly.

Issues

Is the requestor entitled to reimbursement for CPT code 99456-W5-NM and 99456-W8-RE?

Findings

1. On the disputed date of service the requestor billed CPT code 99456-W5-NM and 99456-W8-RE.

2. The respondent denied reimbursement for the disputed services based upon reason codes "97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

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

   - 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."

   - 28 Texas Administrative Code §134.210(e) states, " The following division modifiers shall be used by health care providers billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes: (23) W8, designated doctor examination for return to work--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining the ability of injured employee to return to work."

   - 28 Texas Administrative Code §134.235 states "The following shall apply to return to work (RTW)/evaluation of medical care (EMC) examinations. When conducting a division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier "RE." In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title and shall include division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

4. The division finds the respondent's denial of payment is not supported because the disputed services were not unbundled from any other service rendered on the disputed date.

5. The requestor supported billing CPT code 99456-W5-NM because based upon the evaluation the claimant had not reached MMI; and 99456-W8-RE because claimant was able to return to work on light duty.

6. Per the above referenced statutes, the requestor is due $350.00 for the MMI evaluation and $500.00 for the 17284684

7. return to work evaluation, for a total of $850.00. The respondent paid $0.00. The requestor is due the difference between MAR and amount paid of $850.00**.**

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $850.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $850.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		07/11/2018
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.