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**
JESSE O. SCHNERINGER, DC

**Respondent Name**
NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**
M4-18-3783-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
JUNE 4, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "I was ordered to perform MMI/IR. I submitted medical and billing payment was denied stating that a modifier was required/missing. I submitted a letter from TDI-DWC indicating that no modifier is required for MMI when the patient is at MMI, please see included letter."

**Amount in Dispute:** $650.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Our bill audit company has determined no further payment is due…The provider needs to tell us what the component modifier is for CPT 99456-W5-$300.00 charge."

**Response Submitted By:** Gallagher Bassett

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| December 14, 2017 | CPT Code 99456-W5<br>Designated Doctor Evaluation<br>Maximum Medical Improvement Examination (MMI) | $350.00 | $350.00 |
| | CPT Code 99456-W5-WP<br>Impairment Rating Evaluation | $300.00 | $300.00 |
| TOTAL | | $650.00 | $650.00 |

## *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 §134.240, 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. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 16-Claim/service lacks information or has submission/billing error(s). Which is needed for adjudication.

**Issues**

Is the requestor due reimbursement for codes 99456-W5 and 99456-W5-WP?

**Findings**

1. On the disputed date of service, the requestor billed CPT codes 99456-W5 and 99456-W5-WP. The respondent denied payment stating "The procedure code is inconsistent with the modifier used or a required modifier is missing."

2. To determine if reimbursement is due the division refers to the following statute:

   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)(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(4)(C)(iii) states, "If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier 'WP.' Reimbursement shall be 100 percent of the total MAR."

   28 Texas Administrative Code §134.250(3)(C) states, "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT code 99456. Reimbursement shall be $350."

   28 Texas Administrative Code §134.250 (4)(C)(i)(II) states, "The following applies for billing and reimbursement of an IR evaluation. (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (II) upper extremities and hands."

   28 Texas Administrative Code §134.250 (4)(C)(ii)(II) states, "The MAR for musculoskeletal body areas shall be as follows: If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area."

3. The division finds that the requestor broke down the MMI/IR evaluation and billed for each component separately on two lines instead of one. The provider used the appropriate modifiers to support an MMI/IR evaluation. The division finds the respondent's denial is not supported.

4. Based upon the submitted report, the requestor performed a MMI/IR with range of motion and assigned a 2% WP impairment rating. Per the above referenced statutes, the requestor is due $350.00 for the MMI evaluation and $300.00 for the ROM method for IR, for a total of $650.00. The respondent paid $0.00. The requestor is due the difference between MAR and amount paid of $650.00**.**

**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 $650.00.

## *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 $650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 7/11/2018<br>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**.