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
DAVID BRADLEY, DC

Respondent Name
TX PUBLIC SCHOOL WC PROJECT

MFDR Tracking Number
M4-18-4725-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
AUGUST 3, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier is required to pay Designated Doctor exams."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent properly paid Requestor for his designated doctor evaluation in accordance with the provisions of Rule 134.204(j)(3) and (4). Consequently, Respondent is not liable for payment of an additional $150 associated with Requestor's examination of May 3, 2018."

Response Submitted By: Creative Risk Funding, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 3, 2018	CPT Code 99456-W5-WP (X4) Designated Doctor Evaluation	$150.00	$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 §134.240, 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:
   - 16-Claim/service lacks information or has submission/billing error(s).

- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3
- Notes: Reconsideration …Original payment amount is correct. Arthritis is not a musculoskeletal or a nonmusculoskeletal body area. Please see rule 134.204(J)(4)(C)(ii)(II).

Issues

Is the requestor due additional reimbursement of $150.00 for code 99456-W5-WP(X4)?

Findings

1. On the disputed date of service, the requestor billed $1,250.00 for CPT code 99456-W5-WP (X4). The respondent paid $950.00 based upon the fee guideline. The respondent contends that additional reimbursement is not due because, "Respondent properly paid Requestor for his designated doctor evaluation in accordance with the provisions of Rule 134.204(j)(3) and (4)."

2. To determine if additional 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) 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: (I) spine and pelvis; (II) upper extremities and hands; and (III) lower extremities (including feet)."

   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; and (-b-) $150 for each additional musculoskeletal body area."

   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 (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); and (III) mental and behavioral disorders."

28 Texas Administrative Code §134.250 (4)(D)(v) states, "The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150."

3. The requestor is seeking additional reimbursement of $150.00 for the impairment ratings. A review of the report indicates, "The range of motion model for impairment rating for the knee…the shoulder…Arthritis is not ratable in the shoulder region…the abdominal contusion component has no residual effects…"

4. The division finds the following based upon the submitted report and above referenced statute:

- The submitted report supports requestor performed a MMI/IR evaluation.
- Per 28 Texas Administrative Code §134.250 (4)(C) and (4)(D)(i) the requestor supported IR of 2 musculoskeletal body areas and 1 non-musculoskeletal area.
- Per 28 Texas Administrative Code §134.250 (4)(C) the MAR for musculoskeletal body areas for ROM method is : $300.00 for first and $150.00 for the second .
- Per 28 Texas Administrative Code §134.250 (4)(D)(v) the MAR for non-musculoskeletal body area is $150.00.
- Total MAR for IR is $600.00.
- Per 28 Texas Administrative Code §134.250(3)(C) the MAR for MMI evaluation is $350.00.
- The total MAR for MMI/IR is $950.00. The respondent paid $950.00 As a result, additional reimbursement is not recommended.

Conclusion

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

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Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	8/30/2018 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.