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
ENAS PRUITT, MD

MFDR Tracking Number
M4-19-0249-01

MFDR Date Received
SEPTEMBER 17, 2018

Respondent Name
ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative
Box Number 19

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134.."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As previously noted, the carrier reprocessed the provider's bill. He was seeking an additional $300.00. The carrier has issued an EOB that recommends $300.00. We are attaching a copy of that EOB. Accordingly, we would ask that the provider withdraw his request for medical fee dispute resolution."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 29, 2018	CPT Code 99456-W5-WP (X6) Designated Doctor Examination	$300.00	$00.00

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. The services in dispute were reduced/denied by the respondent with the following reason adjustment codes:

- P12-Workers compensation jurisdictional fee schedule adjustment.
- W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor entitled to additional reimbursement for CPT code 99456-W5-WP (X6) rendered on June 29, 2018?

Findings

1. According to the explanation of benefits, the respondent initially paid $1,100.00 for CPT code 99456-W5-WP (X6) rendered on June 29, 2018 based upon the fee guideline. The respondent wrote in the position summary that once bill was reprocessed an additional allowance of $300.00 was posted on October 17, 2017 for a total of $1,400.00. At the time of this review, the requestor had not withdrawn the request for dispute resolution.
2. Box 36 of the DWC-032 dated June 1, 2018, orders the claimant to attend a designated doctor examination for MMI/IR.
3. Box 37 of the DWC-032 lists all injuries to be comensable as:
   - Cervical strain
   - Chest laceration
   - Lower abdominal strain
   - Right foot/ankle strain
   - Contusion to the head
   - Bilateral hand laceration.
4. On the disputed date of service the requestor billed 99456-W5-WP (X6).
5. The requestor reported the following findings on the Designated Doctor Evaluation report:
   - MMI: May 7, 2018
   - Cervical Spine: 0% IR
   - Chest: 0% IR
   - Abdomen: 0% IR
   - Right Foot/ankle: 0% IR
   - Head Contusion: 0% IR
   - Bilateral Hands: 0% IR
6. To determine the appropriate reimbursement the division refers to the following statutes:
   - 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)(I)(II) states, "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."

- 28 Texas Administrative Code §134.250 (4)(C)(ii) states, "The MAR for musculoskeletal body areas shall be as follows:
  - (I) $150 for each body area if the diagnosis related estimates (DRE) method found in the AMA Guides fourth edition is used.
  - (II) 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)(D)(i)(I)(II) states, "The following applies for billing and reimbursement of an IR evaluation. (D) 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."

7. The Division reviewed the submitted documentation and finds the following:

   - The requestor billed 99456-W5-WP (X6) for the MMI/IR.
   - Per the DWC 32, the compensable injury was to "Cervical strain, Chest laceration, Lower abdominal strain, Right foot/ankle strain, Contusion to the head and Bilateral hand laceration."
   - The requestor billed for 3 musculoskeletal body areas (spine, upper and lower extremities) and 3 non-musculoskeletal body areas (head, chest and abdomen).
   - Per 28 Texas Administrative Code §134.250(3)(C) the appropriate reimbursement for the MMI evaluation is $350.00.
   - The report indicates the requestor performed ROM of spine, upper and lower extremities; therefore, the total reimbursement is $600.00 per 28 Texas Administrative Code §134.250 (4)(C)(ii)(II)(a and b).
   - Per 28 Texas Administrative Code §134.250 (4)(D)(v) the MAR for IR of 3 non-musculoskeletal areas = $150.00 X 3 = $450.00.
   - Total for IR is $1,050.00.
   - The total due for the MMI/IR is $1,400.00. The respondent paid $1,400.00. The requestor is due the difference between MAR and paid of $0.00**.**

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 $00.00.

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.

Authorized Signature

		11/20/2018
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.