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
DR JOSEPH COLEMAN

Respondent Name
FEDERAL INSURANCE CO

MFDR Tracking Number
M4-19-0635-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
OCTOBER 4, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Under the facts of this case, Joseph Coleman, DC provided a DWC 69 for the compensable diagnosis…of which he opined Claimant with MMI and a 0% IMPAIRMENT RATING. Reimbursement for CPT code 99456 (-W5) was, issued per the division fee guideline for workers' compensation specific services. An 'alternate' DWC 69 was, submitted to address outstanding extent of injury questions, of which Joseph Coleman, DC opined Claimant had not reached MMI. Therefore, an impairment rating was not calculated."

Response Submitted By: Corvel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 14, 2018	CPT Code 99456-W5-MI Maximum Medical Improvement/Impairment Rating Evaluation	$50.00	$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 §134.250, effective July 7, 2016, sets the reimbursement guidelines for Maximum Medical Improvement Evaluations and Impairment Rating Examinations.
3. The services in dispute were reduced/denied by the respondent with the following reason adjustment code(s):
   - MI-Multiple impairments.
   - 234-This procedure is not paid separately.

Issues

Is the requestor due reimbursement for code 99456-W5-MI?

Findings

The issue in dispute is whether the requestor is due reimbursement of $50.00 for code 99456-W5-MI.

The respondent contends that reimbursement is not due because “An ‘alternate’ DWC 69 was, submitted to address outstanding extent of injury questions, of which Joseph Coleman, DC opined Claimant had not reached MMI. Therefore, an impairment rating was not calculated.”

28 Texas Administrative Code §134.250(4)(B) states, “When multiple IRs are required as a component of a designated doctor examination under this title, the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code.”

The requestor wrote “The division is requesting that I discuss MMI, impairment rating as well as extent of injury I mandated to offer an alternate impairment rating. If in fact, in the division warrants that the compensable injury includes the injuries in question to include right hand and right wrist carpal tunnel syndrome then this patient would be considered not at MMI as additional care would be warranted in order to resolve his median nerve entrapment.”

A review of the submitted report indicates the claimant had not reached MMI; therefore, an impairment rating was not calculated to support billing CPT code 99456-W5-MI. The division finds the respondent’s denial of payment is supported.

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.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/20/2018 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.