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
STACY CROFT, DC

Respondent Name
AMERICAN INTERSTATE INSURANCE

MFDR Tracking Number
M4-19-0900-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
OCTOBER 16, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS."

Amount in Dispute: $850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Amerisafe never received a bill for this date of service."

Respondent's Supplemental Position Summary dated November 13, 2018: "Please see attached payment of $850.00 payable to LM Exams. Check was issued on 11/12/2018, and was mailed to the provider on 11/13/2018. Attached for your review is a copy of the check, and the check number is 0013699880."

Response Submitted By: Amerisafe Risk Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 22, 2018	CPT Code 99456-W5-NM	$350.00	$0.00
	CPT Code 99456-W8-RE	$500.00	$0.00
TOTAL		$850.00	$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 policy billing and reimbursement guidelines for Maximum Medical Improvement (MMI) and/or Impairment Rating (IR) examinations.
3. Neither party to this dispute submitted copies of the explanation of benefits to support denial/reduction of payment for the disputed services.

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 wrote “Please see attached payment of $850.00 payable to LM Exams. Check was issued on 11/12/2018, and was mailed to the provider on 11/13/2018. Attached for your review is a copy of the check, and the check number is 0013699880

3. 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.”

4. 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.”

5. 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.” A review of the report indicates, “the examinee was found to have not reached maximum medical improvement (MMI).”

6. 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.”

7. The division finds the requestor did not bill for the evaluation in accordance with 28 Texas Administrative Code §134.240(1)(A)(B) because billed with modifier “W5,” and claimant was not at MMI and IR was not performed; however, the respondent issued payment of $350.00. As a result, additional reimbursement is not recommended.

8. 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.”

9. 28 Texas Administrative Code §134.240(1)(E) states, “The following shall apply to designated doctor examinations. (1) 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: Ability of the employee to return to work shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier ‘W8’."

10. The division finds the requestor billed for the return to work evaluation in accordance with 28 Texas Administrative Code §134.235 and 28 Texas Administrative Code §134.240(1)(E). The respondent paid $500.00 for the return to work evaluation; therefore, the requestor is not due additional reimbursement.

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 $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

		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.