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
MICHAEL MAIER, MD

Respondent Name
FORT BEND COUNTY

MFDR Tracking Number
M4-19-2049-01

Carrier's Austin Representative
Box Number 29

MFDR Date Received
DECEMBER 10, 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: "After review of the bill, there was an additional allowance of $150.00…on 11/12/2018."

Response Submitted By: York

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 14, 2018	CPT Code 99456-W5-WP (X5) Maximum Medical Improvement/Impairment Rating Evaluation	$150.00	$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 insurance carrier reduced payment for the disputed services based upon the following claim adjustment reason codes:
    - P12-Workers' compensation jurisdictional fee schedule adjustment.
    - P14-The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.
    - DDE/MMI REACHED -$350/IR-UPPER EXTREMITY@ROM, LOW EXTREMITY@ROM-$150, & 2-NON-MUSCLOSELETAL@DRE OF BODY SYSTEM-HEAD/CONCUSSION-$1250 & BODY STRUCTURE (INCLUDING SKIN)-SCALP/FACIAL-$150.00. ADDITIONAL PAYMENT OWE OF $150.00 ON THIS AUDIT. PREVIOUS PAYMENT MADE UNDER BILL ID#9575867, CHECK #44333 RELEASED ON 08/24/18.
    - W3-REPORTING PURPOSES ONLY.

Issues

Is the requestor due reimbursement of $150.00 for code 99456-W5-WP(X5)?

Findings

On August 14, 2018, the claimant attended a Designated Doctor evaluation to determine MMI/IR. The requestor billed the respondent $1,400.00 for the MMI/IR evaluation with CPT code 99456-W5-WP(X5). The respondent paid $1,100.00. The issue in dispute is whether the requestor is due additional reimbursement of $150.00.

The requestor reported the following findings on the Designated Doctor Evaluation report:

- MMI: January 29, 2018
- Scalp IR: 0%
- Bilateral Knee IR ROM: 0%
- Bilateral Elbow IR: 0%
- Concussion IR: 0%
- Facial Contusion IR: 0%

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; and (III) lower extremities (including feet)."

- 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)(l)(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."

The Division reviewed the submitted documentation and finds the following:

- The requestor billed 99456-W5-WP (X5) for the MMI/IR in accordance with 28 Texas Administrative Code §134.240 and §134.250(3) and (4).
- 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 testing on lower extremities; therefore, the total reimbursement is $300.00 per 28 Texas Administrative Code §134.250 (4)(C)(ii)(II)(a).
- The report indicates DRE IR for Upper extremities; therefore, the total reimbursement is $150.00 per 28 Texas Administrative Code §134.250 (4)(C)(ii)(I).
- Per 28 Texas Administrative Code §134.250 (4)(D)(v) the MAR for IR of 2 non-musculoskeletal areas, Concussion and Face/Scalp = $300.00.
- Total for IR is $750.00.
- The total due for the MMI/IR is $1,100.00. The respondent paid $1,100.00. The requestor is due the difference between MAR and paid of $00.00**.**

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

Signature	Medical Fee Dispute Resolution Officer	1/30/2019 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.