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
GILBERT MAYORGA, MD

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-19-3402-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
MARCH 11, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please allow to serve as a request for medical fee dispute resolution for designated doctor evaluation…the patient was seen for …MMI, impairment rating, as well as return to work."

Amount in Dispute: $850.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "since the provider is designated doctor, the carrier is going to reprocess the provider's bill. We disagree with the DWC-60 portion that indicates that the provider was not reimbursed for the MMI evaluation."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2018	CPT Code 99456-W5-NM	$350.00	$00.00
	CPT Code 99456-W8-RE	$00.00	$00.00
TOTAL		$00.00	$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 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. Texas Labor Code §408.027, effective September 1, 2007, sets out the rules for timely submission of a claim by a health care provider.
4. 28 Texas Administrative Code §102.4(h), effective May 1, 2005, sets out rules to determine when written documentation was sent.

5. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the health care providers billing procedures.
6. 28 Texas Administrative Code §133.250, effective March 20, 2014, sets out the medical bill processing and audit by insurance carriers procedures.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 4150-An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed.
   - 29-The time limit for filing has expired.
   - 4271-Per TX Labor Code Sec. 413.016, providers must submit bills to payors within 95 days of the date of service.

Issues

1. Is the requestor entitled to reimbursement for CPT code 99456-W5-NM?
2. Does the documentation support that the disputed bill for code 99456-W8-RE was submitted timely?

Findings

1. On March 14, 2018, the claimant attended a Designated Doctor Examination to determine MMI/IR and claimants' ability to return to work. The requestor billed the respondent $850.00 for CPT code 99456-W5-NM, and 99456-W8-RE.

2. The requestor reported the following findings on the Designated Doctor Examination report:
   - Claimant is not at MMI
   - Claimant can return to work with restrictions

3. To determine the appropriate reimbursement the division refers to the following statutes:

   - 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."

   - 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."

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

   - The requestor billed 99456-W5-NM for the MMI evaluation.
   - Per 28 Texas Administrative Code §134.250(3)(C) the appropriate reimbursement for the MMI evaluation is $350.00.
   - Per the submitted explanation of benefits, the respondent issued payment of $350.00 for CPT code 99456-NM. As a result, additional reimbursement is not recommended.

5. According to the explanation of benefits, the respondent denied reimbursement for CPT code 99456-W8-RE based upon reason codes: "29-The time limit for filing has expired," and "4271-Per TX Labor Code Sec. 413.016, providers must submit bills to payors within 95 days of the date of service."

   To determine if CPT code 99456-W8-RE is eligible for reimbursement the division refers to the following statute:

   - 28 Texas Administrative Code §133.250(d) states "A written request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill."

   - 28 Texas Administrative Code §133.250(i) states "If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill after reconsideration, the health care provider may request medical dispute resolution in accordance with the provisions of Chapter 133, Subchapter D of this title (relating to Dispute of Medical Bills)."

   - Texas Labor Code §408.027(a) states, "A health care provider shall submit a claim for payment to the

insurance carrier not later than the 95th day after the date on which the health care services are provided to the injured employee. Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment."

- 28 Texas Administrative Code §102.4(h), states, "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."

6. The division reviewed the documentation and finds:

- The requestor's original bill listed CPT code 99456-W5-NM and 99080 in the amount of $365.00.
- The fax date stamp indicates the respondent received this bill on March 21, 2018.
- The respondent audited this bill on March 26, 2018.
- The requestor submitted a "corrected bill" for CPT code 99456-W5-NM, 99456-W8-RE and 99080 in the amount of $865.00.
- The fax date stamp indicates the respondent received this bill on March 4, 2019.
- The corrected bill does not reference the same billing codes and dollar amount from the original bill; therefore, bill was not sent in accordance to 28 Texas Administrative Code §133.250(d).
- The division finds the requestor did not support the bill for code 99456-W8-RE was sent to insurance carrier timely in accordance with Texas Labor Code §408.027(a).
- The division concludes the respondent's denial of payment based upon reason code "29" is supported.

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

Signature	Medical Fee Dispute Resolution Officer	04/11/2019 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.