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
Philip M. Glencross, M.D., M.P.H., P.A.

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-19-4306-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 31, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Commission order, MMI/IR was to be determined in this case by the Designated Doctor. Compensable musculoskeletal areas rated included (2) spine and left shoulder. A full physical examination was performed with Left shoulder billed using ROM. Service Code 99456 W5 WP for $350 + $300 for first musculoskeletal body area (Shoulder ROM) + $150 for second musculoskeletal body area (Spine)."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider is billing 1 UOS
99456/W5.WP $350.00 + $300 (1st area ROM) = $$650.00
Bill is priced correct as billed. If the provider is performing ROM for 2 body areas then they need to bill 2 UOS."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2019	Designated Doctor Examination	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

- Z710 – The charge for this procedure exceeds the fee schedule allowance.
- 00663 Reimbursement has been calculated according to state fee schedule guidelines
- 93 – No claim level adjustments.
- 950 – This bill is a reconsideration of a previously reviewed bill, allowance amounts do not reflect previous payments.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Dr. Glencross is seeking additional reimbursement for a designated doctor examination to determine the maximum medical improvement and impairment rating. The insurance carrier reduced the bill in question citing the medical fee guidelines.

The designated doctor is required to bill an examination to determine maximum medical improvement with CPT code 99456 and modifier "W5."[1] Reimbursement is $350.00 for this examination.[2] The submitted documentation supports that Dr. Glencross performed an evaluation of maximum medical improvement as ordered by the DWC. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

The designated doctor is required to bill an examination to determine the impairment rating of an injury with CPT code 99456 and modifier "W5."[3] The number of body areas are required to be indicated in in the units column of the billing form.[4] The submitted documentation supports that Dr. Glencross provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion.

Review of the submitted documentation finds that the bill for the services in question included one body area in the units column of the billing form. Reimbursement is $300.00 for one musculoskeletal body area if a full physical evaluation with range of motion is performed.[5]

The DWC concludes that the total allowable for the disputed services is $650.00. Per submitted explanation of benefits, dated April 5, 2019, the insurance carrier reimbursement this amount. No further reimbursement is recommended.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	July 30, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Codes §§134.250(3)(C) and 134.240(1)(B)
[2] 28 Texas Administrative Code §134.250(3)(C)
[3] 28 Texas Administrative Codes §§134.250(4)(A) and 134.240(1)(A)
[4] 28 Texas Administrative Codes §§134.250(4)(A)
[5] 28 Texas Administrative Codes §§134.250(4)(C)(ii)(II)(-a-)

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **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.