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
GENEVA MEDICAL MANAGEMENT, INC

Respondent Name
EL PASO ISD

MFDR Tracking Number
M4-20-0086-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
SEPTEMBER 13, 2019

REQUESTOR'S POSITION SUMMARY

"These services were requested and prescribed by the Division. The above referenced designated doctor performed the MMI examination and assigned the IR, but he did not perform the range of motion, strength, or sensory testing of the musculoskeletal body area(s), that means he should bill using the appropriate MMI COT code 99456 with the component modifier -26. Reimbursement for the examining doctor is 80% of the MAR.

The physical therapist and/or health care provider other than the examining doctor that performs the range of motion, strength, or sensory testing of the musculoskeletal body, the physical therapist and/or health care provider will bill with the component -TC. In this instance, reimbursement to the physical therapist and/or health care provider is 20% of the MAR.

The bills from the two parties must be coordinated and billed appropriately and should be billed at the same time for the correct reimbursement."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 23, 2019	CPT Code 99456-W5-26 Designated Doctor Evaluation (DD)	$250.00	$300.00
	CPT Code 99456-W5-TC	$50.00	
TOTAL		$300.00	$300.00

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 (DWC).

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.210, effective July 7, 2016, provides the medical fee guideline for DWC specific services.
3. 28 TAC §134.240, effective July 7, 2016, sets the reimbursement guidelines for Designated Doctor Examinations.
4. 28 TAC §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 with the following claim adjustment codes:

- 29-The time limit for filing has expired.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 289-The recommended allowance is based on the value for the technical component of the service performed.
- 298- The recommended allowance is based on the value for the professional component of the service performed.
- 3384-Recution based on the modifier(s) billed.
- 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 a.
- 89-Professional fees removed from charges.
- W3-Additional payment made on appeal/reconsideration.
- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 937-Service(s) are denied based on HB7 provider timely filing requirement. A provider must submit a medical bill to the insurance carrier on or before the 95th day after the date of service.
- 1241-No additional reimbursement allowed after review of appeal/reconsideration/request for second review.

Issues

Is the requestor entitled to additional reimbursement for Designated Doctor examination performed on April 23, 2019?

Findings

1. The Austin carrier representative for El Paso ISD is Downs Stanford, PC. Downs Stanford, PC acknowledged receipt of the copy of this medical fee dispute on September 20, 2019. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. On the disputed date of service, the requestor billed $1,300.00 for CPT code 99456-W5-26 and 99456-W5-TC. The respondent paid $350.00 based upon the fee guideline. The requestor contends that an additional reimbursement of $300.00 is due for the services.

3. The respondent initially reimbursed the requestor $350.00 for the disputed services based upon the fee guideline.

4. The following statute is applicable to the disputed services:

- 28 TAC §134.210(b)(2) states, "Payment policies relating to coding, billing, and reporting for workers' compensation specific codes, services, and programs are as follows: 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 TAC §134.210(e)(9) and (20) states, "The following division modifiers shall be used by health care providers billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes:
  (9) TC, technical component--This modifier shall be added to the CPT code when the technical component of a procedure is billed separately
  (20) W5, designated doctor examination for impairment or attainment of MMI--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining impairment caused by the compensable injury and in attainment of MMI.
- 28 TAC §134.240(1)(A) and (B) 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:

  (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 TAC §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 TAC §134.250 (4)(C)(i)(III) states, "The following applies for billing and reimbursement of an IR evaluation. (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (III) lower extremities (including feet)."
- 28 TAC §134.250 (4)(C)(ii)(II)(a) states, "The following applies for billing and reimbursement of an IR evaluation. 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."
- 28 TAC §134.250(4)(C)(iv) states, "The following applies for billing and reimbursement of an IR evaluation. (iv) If, in accordance with §130.1 of this title, the examining doctor performs the MMI examination and assigns the IR, but does not perform the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the examining doctor shall bill using the appropriate MMI CPT code with CPT modifier "26." Reimbursement shall be 80 percent of the total MAR.
- 28 TAC §134.250(4)(C)(v) states, "The following applies for billing and reimbursement of an IR evaluation. (v) If a health care provider, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the health care provider

shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the health care provider must be certified. Reimbursement shall be 20 percent of the total MAR.

5. The DWC-032 dated February 11, 2019, orders the claimant to attend a Designated Doctor examination for MMI/IR evaluation of the claimant's lower extremities.
6. The DWC reviewed the submitted documentation and finds the following:

   - The requestor is billing for both the DD services and the physical therapist and/or health care provider's services with CPT codes 99456-W5-26 and 99456-W5-TC for the IR.
   - Per 28 TAC §134.250(3)(C) the appropriate reimbursement for the MMI evaluation is $350.00.
   - Per 28 TAC §134.250 (4)(C)(ii)(II)(a) the MAR for the IR of the lower extremities is $300.00.
   - The total due for the MMI/IR is $650.00. The respondent paid $350.00. As a result, the requestor is due additional reimbursement of $300.00**.**

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the DWC has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The DWC hereby ORDERS the respondent to remit to the requestor the amount of $300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		12/11/2019
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, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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 with the DWC. **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.