



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

DAVID WEST, DO

Respondent Name

TRAVELERS INDEMNITY CO

MFDR Tracking Number

M4-20-0245-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

SEPTEMBER 27, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CERTIFYING DOCTOR RATED 2 SEPARATE ISSUES, THE LOWER EXTREMITY AND THE RIBS/STERNUM."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the billing and reimbursement and determined the Provider was appropriately reimbursed under Rule 134.250."

Response Submitted By: Travelers

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: June 3, 2019, CPT Code 99456-WP (X2) Certifying Doctor Examination, \$150.00, \$150.00

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 §133.307 (TAC), effective May 31, 2012 sets out the procedures for resolving a medical fee dispute.
2. 28 TAC §134.250, effective July 7, 2016, sets the reimbursement guidelines for Maximum Medical Improvement Evaluations and Impairment Rating Examinations.
3. The services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:
- 863-Reimbursement is based on the applicable reimbursement fee schedule.
- 947-Upheld. No additional allowance has been recommended.
- P12-Workers' compensation jurisdictional fee schedule adjustment.
- 309-The charge for this procedure exceeds the fee schedule allowance.

- 193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

### **Issues**

Is the requestor due additional reimbursement of \$150.00 for code 99456-WP(X2)?

### **Findings**

1. The requestor billed \$800.00 for an alternate MMI/IR examination, CPT code 99456-WP (X2), rendered on June 3, 2019. According to the explanation of benefits, the respondent paid \$650.00 for CPT code 99456-WP (X2) based upon the fee guideline. The requestor is seeking medical fee dispute resolution in the amount of \$150.00.
2. The following statute is applicable to the disputed services:
  - 28 TAC §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 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)(I) and (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; and (II) lower extremities (including feet)."
  - 28 TAC §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."

The DWC reviewed the submitted documentation and finds the following:

- The requestor billed 99456-WP (X2) for the MMI/IR in accordance with 28 TAC §134.250(3) and (4).
- Per 28 TAC §134.250(3)(C) the appropriate reimbursement for the MMI evaluation is \$350.00.
- The report indicates the requestor performed ROM testing on the Lower Extremity and DRE testing of the Spine (Ribs and sternum); therefore, the MAR is \$450.00 per 28 TAC §134.250 (4)(C)(ii).
- The total due for the MMI/IR is \$800.00. The respondent paid \$650.00. The requestor is due the difference between MAR and paid of \$150.00.

### **Conclusion**

For the reasons stated above, the DWC finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$150.00.

**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 \$150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

12/20/2019

***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 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 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 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.**