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**
LAWSON, WILLIAM MARTIN

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**
M4-20-2251-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
May 13, 2020

## *REQUESTOR'S POSITION SUMMARY*

"The examination was for the spine, and upper extremities. The examination addressed extent of injury for which I have listed 3 scenarios and found the claimant not at MMI. The billing codes noted at 99456 W5 NM, 99456 W6 RE, and 99456 MI (2 units). The billed amount is $1250. Your payment to this office is erroneous at $600. Due to the claimant not at MMI, the billing code 99456 W5 NM should have been billed at $350."

**Amount in Dispute:** $350.00

## *RESPONDENT'S POSITION SUMMARY*

"… audit staff denied 99456-W5-NM as documentation submitted from the provider indicates that scenario # 1 was at MMI … Texas Mutual denied the bill to the provider, the denial notified the provider on the EOB that cpt code needed a valid code and/or modifier. 'NM' modifier is not appropriate due to the MMI/IR rating."

**Response Submitted by:** Texas Mutual Insurance Company

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| December 18, 2019 | Designated Doctor Examination | $350.00 | $350.00 |

## *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 §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:
    - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
    - CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
    - 732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed.
    - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
    - 714 – Accurate CPT/HCPCS, date of service, units, days supply, modifiers are essential for reimbursement. Submit corrections w/i 95 days from DOS.

**Issues**

Is William M. Lawson, D.C. entitled to additional reimbursement for the examination in question?

**Findings**

Dr. Lawson is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement, impairment rating, and extent of the compensable injury. Dr. Lawson billed the examination with the following procedure codes:

- 99456-W6-RE (1 unit): $500.00
- 99456-W5-NM (1 unit): $650.00
- 99456-MI (2 units): $100.00

Texas Mutual Insurance Company reimbursed procedure codes 99456-W6-RE and 99456-MI in full. These services will therefore not be reviewed in this dispute.

Texas Mutual Insurance denied payment for procedure code 99456-W5-NM based on incorrect modifier. If the designated doctor determines that maximum medical improvement has not been reached, the designated doctor is required to bill the examination with CPT code 99456 and modifier "NM."[1] Reimbursement is $350.00 for this examination.[2]

The DWC finds that Dr. Lawson's report included findings that the injured employee was not at maximum medical improvement. For this reason, the DWC concludes that Dr. Lawson is entitled to an additional reimbursement of $350.00.

**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 $350.00.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $350.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

[1] 28 TAC §134.250(2)(A)
[2] 28 TAC §134.250(3)(C)

**Authorized Signature**

| | | |
|---|---|---|
| | | June 25, 2020 |
| 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 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 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. **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**.