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
JKB MEDICAL EXAMS

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-21-0387-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 6, 2020

REQUESTOR'S POSITION SUMMARY

Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of adjudication.

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

"The provider billed $1,100.00 for an MMI and an impairment rating evaluation. The DWC-60 does not indicate that the provider has already been reimbursed $750.00 under the same code. In other words, the provider billed the same code twice."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 7, 2020	Designated Doctor Examination (99456-W5-WP)	$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 §134.240 sets out the fee guidelines for designated doctor examinations.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 50 – These are non-covered services because this is not a deemed a 'medical necessity' by the payer.
   - Notes: "NO ALLOWANCE CHANGE"

Issues

1. Is the insurance carrier's reason for reduction of payment supported?
2. Is JKB Medical Exams entitled to additional reimbursement?

Findings

1. JKB Medical Exams is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating. The insurance carrier reduced reimbursement for this examination based on medical necessity.

   The insurance carrier is required to reimburse designated doctor examinations unless otherwise prohibited by statute, order, or rule.[1] The insurance carrier submitted no evidence to support that reimbursement for the portion of the examination in question was prohibited.

   The DWC finds that the examination in question is not subject to dismissal based on medical necessity.

2. The designated doctor is required to bill an examination to determine maximum medical improvement with CPT code 99456 and modifier "W5."[2] Reimbursement is $350.00 for this examination.[3] The submitted documentation supports that James Bales, M.D. 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."[4] If the examining doctor is required to include modifier "WP" if the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body areas.[5]

   Review of the submitted documentation finds that Dr. Bales performed impairment rating evaluations of the left shoulder with range of motion testing, rib fractures, left lung contusions, and the left eye. Submitted explanation of benefits dated August 22, 2020 indicates that the insurance carrier reimbursed this portion of the examination in full.

   The total allowable reimbursement for the examination in question is $1,100.00. The insurance carrier paid $750.00. An additional reimbursement of $350.00 is recommended.

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.

Authorized Signature

		January 29, 2021
Signature	Medical Fee Dispute Resolution Officer	Date

[1] TIC §408.0041 (h)
[2] 28 TAC §§134.250(3)(C) and 134.240(1)(B)
[3] 28 TAC §134.250(3)(C)
[4] 28 TAC §§134.250(4)(A) and 134.240(1)(A)
[5] 28 TAC §§134.250(4)(C)(iii)

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.