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
FORSTER, SIMON JOHN

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-21-1187-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 12, 2021

REQUESTOR'S POSITION SUMMARY

"We are submitting a request for reconsideration in response to a denial of the $157.47 for the Designated Doctor Referred Exam performed on 10/08/2020. It is our position that you, the carrier, are in error for denying reimbursement for code 97750 performed in conjunction with a designated doctor's evaluation on this date of service."

Amount in Dispute: $157.47

RESPONDENT'S POSITION SUMMARY

"The provider was reimbursed $500 under CPT code 99456 RE W6. The carrier's position was explained on its initial EOB dated December 1, 2020. When billed in conjunction with CPT code 99456 RE W6, service procedure codes between 90000 and 99999 are disallowed … Even when CPT code 99456 has a modifier, that does not allow it to override the relationship such that reimbursement for CPT code 97750 is not allowed."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 8, 2020	Physical performance test or measurement	$157.47	$157.47

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 §134.203 sets out the fee guidelines for professional services.
3. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine extent of injury.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 906 – In accordance with clinical based coding edits (National Correct Coding Initiative/Outpatient Code Editor), component code of comprehensive medicine, evaluation and management services procedure (90000-99999) has been disallowed.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 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.

Issues

1. Is New Hampshire Insurance Company's denial of payment supported?
2. Is Simon Forster, D.C. entitled to reimbursement for the service in question?

Findings

1. Dr. Forster is seeking reimbursement for a physical performance test performed as part of a designated doctor examination to determine the extent of the compensable injury.

   An examination by a designated doctor to determine the extent of a compensable injury, represented by CPT code 99456 with modifiers "W6" and "RE," is a division-specific service not subject to Medicare billing rules.[1] If the doctor determines that additional testing is required to make a determination, the testing "shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."[2]

   Therefore, the insurance carrier's denial of this service is not supported.

2. Because the insurance carrier failed to support its denial of payment, Dr. Forster is entitled to reimbursement of these services at three units.

   Documentation submitted to the DWC supports that Dr. Forster performed a physical performance test for the left shoulder. Documentation states that the total evaluation time was 45 minutes. The physical performance test, represented by CPT code 97750, was billed at three units for each 15 minutes.

   Reimbursement for the services in question are based on Medicare policies using the conversion factor determined by the DWC for the appropriate year.[3] The conversion factor for 2020 is $61.17.[4] Therefore, the maximum allowable reimbursement is $190.49. Dr. Forster is seeking $157.47. This amount is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. 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 $157.47.

[1] 28 TAC §134.210(a)
[2] 28 TAC §134.235
[3] 28 TAC §134.203(b) and (c)
[4] https://www.tdi.texas.gov/wc/fee/conversionfactors.html#conv

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 $157.47, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		May 13, 2021
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.