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
SUTTLE, KAREN SANDRA THORNTON

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-21-1519-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 29, 2021

REQUESTOR'S POSITION SUMMARY

"99456 W5 WP MMI = $350.00
IR – ANKLE W/ROM = $300.00
IR – FACE = $150.00
IR – EYE = $150.00 …"

Amount in Dispute: $600.00

RESPONDENT'S POSITION SUMMARY

"The impairment rating was for the right ankle, face and left eye. The provider is entitled to reimbursement based upon body areas. It is the carrier's position that the face and left eye are part of the same body area and should not be billed separately. Moreover, the provider has already been reimbursed and is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 6, 2020	Designated Doctor Examination (99456-W5-WP)	$600.00	$600.00

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:
   - Workers' compensation jurisdictional fee schedule adjustment.

- The charge for the procedure exceeds the amount indicated in the fee schedule.
- The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.
- Additional payment made on appeal/reconsideration.

Issues

Is Karen Suttle, M.D. entitled to additional reimbursement for the examination in question?

Findings

Dr. Suttle is seeking additional reimbursement for a designated doctor examination performed on October 6, 2020.

The submitted documentation supports that Dr. Suttle performed an evaluation of maximum medical improvement as ordered by the DWC. The examining doctor is required to bill an examination to determine maximum medical improvement with CPT code 99456 and modifier "W5."[1] The maximum allowable reimbursement (MAR) for this examination is $350.00.[2]

Review of the submitted documentation finds that Dr. Suttle performed impairment rating evaluations of the face, the left eye, and the right ankle with range of motion testing.

The examining doctor is required to bill an examination to determine the impairment rating of an injury with CPT code 99456, modifier "W5,"[3] and modifier "WP" when "the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s)."[4]

The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[5] The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.[6]

Dr. Suttle based the impairment rating of the right ankle on Chapter 3, subchapter 3.2 of the *AMA Guides,* fourth edition.[7] This is the lower extremities subchapter of the musculoskeletal chapter. The lower extremity is considered one body area in the fee guidelines.[8]

Dr. Suttle based the impairment rating of the left eye on Chapter 8, subchapter 8.4 of the *AMA Guides,* fourth edition. This chapter relates the to the visual system, a body system which is considered one body area in the fee guidelines.

Dr. Suttle based the impairment rating of the face on Chapter 9, subchapter 9.2 of the *AMA Guides,* fourth edition. This chapter relates the to the ear, nose, throat, and related structures; a body system which is considered one body area in the fee guidelines.

The total MAR for the determination of impairment rating is $600.00.

The total allowance for the examination in question is $950.00. Submitted documentation supports that the insurance carrier reimbursed $350.00. An additional $600.00 is recommended.

[1] 28 TAC §§134.250(3)(C) and 134.240(1)(B)
[2] 28 TAC §134.250(3)(C)
[3] 28 TAC §§134.250(4)(A) and 134.240(1)(A)
[4] 28 TAC §§134.250(4)(C)(iii)
[5] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[6] 28 TAC §134.250(4)(D)(v)
[7] 28 TAC §134.250(4)(D)(iv)(I)
[8] 28 TAC §134.250(4)(C)(i)(II)

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 $600.00.

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 $600.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		June 9, 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.