



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

PACIFIC BILLING

Respondent Name

NATIONAL INTERSTATE INSURANCE

MFDR Tracking Number

M4-21-1956-01

Carrier's Austin Representative

Box Number 06

MFDR Date Received

July 8, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = \$350.00
IR – W/ROM = \$300.00
TTL = \$650.00"

Amount in Dispute: \$300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In its DWC 60 form Pacific Billing indicates a \$650 charge charge for 99456 W5 WP. However, the initial billing does not reflect a charge of \$650, so it is unclear upon what the disputed amount is based. National cannot determine from the submission whether additional amounts are owed."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 2020	Designated Doctor Examination (99456-W5-WP)	\$300.00	\$300.00

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 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.

Issues

Is Pacific Billing entitled to additional reimbursement for the examination in question?

Findings

Pacific Billing is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating.

The designated doctor is required to bill an examination to determine maximum medical improvement with CPT code 99456 and modifier “W5.”¹ The submitted documentation supports that Steven Anderson, D.C. performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is \$350.00.²

The examining doctor is required to bill an examination to determine the impairment rating of an injury with CPT code 99456 and modifier “W5.”³ Modifier “WP” is added if the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area.⁴

The submitted documentation supports that Dr. Anderson provided an impairment rating of the left shoulder, a musculoskeletal body area, performing a full physical evaluation with range of motion. Reimbursement is \$300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.⁵

The submitted documentation supports that Dr. Anderson is entitled to a total reimbursement of \$650.00 for the examination in question. The insurance carrier paid \$350.00. An additional reimbursement of \$300.00 is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered. For the reasons stated above, the Texas Department of Insurance, Division of Workers’ Compensation (DWC) finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$300.00.

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 \$300.00, 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

August 18, 2021

Date

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-)

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.