TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Jose M. Hernandez, Jr., M.D.

Respondent Name
San Antonio Water System

MFDR Tracking Number
M4-21-2243-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 5, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 9, 2021	Examination to Determine Maximum Medical Improvement and Impairment Rating (99455-WP-V4)	$521.76	$300.00

Requestor's Position

"It is the provider's position that the bill review, Medical Audit Consultants, for employer [redacted] processed CPT code 99455with modifier WP V4 incorrectly and did not provide a reason for the denied reconsideration that was based on a Texas Administrative Codes-RULE §130.1 …, RULE §130.2 …, or RULE §134.250 … Texas MedClinic is seeking the correct payment due of $521.76."

Amount in Dispute: $521.76

Respondent's Position

"The provider's current position is not only inconsistent with its CMS-1500, which requested total reimbursement of $591, it is also inconsistent with the provider's request for reconsideration in which it was claiming that it was entitled to a V4 modifier for the office visit in the amount of

$240 plus $300 for the impairment rating portion of the maximum medical improvement (MMI) and impairment rating evaluation."

Response Submitted by: Flahive, Ogden & Latson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.203 sets out the fee guidelines for professional medical services.

3. 28 TAC §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- W3 – Additional payment made on appeal/reconsideration.
- B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- Notes: "PLEASE NOT CLAIMANT SUSTAINED A [redacted] ONLY. CLAIMANT WAS SEEN ON THREE DATES OF SERVICE. MMI & IR WAS PERFORMED [redacted] DAYS AFTER THE DATE OF INJURY WITH A 0% IR. CPT CODE 99455 WAS BILLED WITH V4 MODIFIER AND WAS REIMBURSED PROPERLY."

Issues

1. Is Jose M. Hernandez, Jr., M.D. entitled to additional reimbursement for the examination in question?

Findings

1. Dr. Hernandez is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating.

   The submitted documentation supports that Dr. Hernandez performed an evaluation of maximum medical improvement (MMI) as the treating doctor.

According to 28 TAC §§134.250 (3)(A), the treating doctor is required to bill an examination to determine maximum medical improvement with CPT code 99455. The treating doctor is required to include "V1," "V2," "V3," "V4," or "V5" to correspond with the last digit of the applicable office visit.

28 TAC §134.250 (3)(A)(i) states that reimbursement is the applicable established patient office visit level associated with the examination. Dr. Hernandez billed the examination in question with modifier V4.

The applicable office visit level that corresponds with this modifier is 99214. The maximum allowable reimbursement (MAR) for this code is based on Medicare payment policies as described in 28 TAC §134.203. The MAR for the MMI portion of the examination in question is $221.76.

Review of the submitted documentation finds that Dr. Hernandez performed impairment rating evaluations of the shoulders with range of motion testing. The rule at 28 TAC §134.250 (4)(C) defines the fees for the calculation of an impairment rating. The MAR for the evaluation of the first musculoskeletal body area performed with range of motion is $300.00.

The total allowable reimbursement for the examination in question is $521.76. The insurance carrier paid $221.76. An additional reimbursement of $300.00 is recommended.

Conclusion

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

DWC finds the requester has established that additional reimbursement of $300.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that San Antonio Water System must remit to Jose M. Hernandez, Jr., M.D. $300.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 29, 2021 Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.