

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

William Edward Smith

Respondent Name

Seabright Insurance Co

MFDR Tracking Number

M4-22-0865-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

January 11, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
November 29, 2021	99456 W5 WP	\$300.00	\$0.00
November 29, 2021	99456 W5 WP	\$0.00	\$0.00
November 29, 2021	99456 W5 WP	\$0.00	\$0.00
November 29, 2021	99456 W5 WP	\$0.00	\$0.00
Total		\$300.00	\$0.00

Requestor's Position

According to Texas law the Fee Schedule reimbursement is \$350 for the determination of MMI status. If MMI status was reached, \$300 is awarded when range of motion measurements are necessary for the 1st body area impairment. An additional \$150.00 is awarded for each additional body area impairment determination. Four body areas (spine, lower extremity; upper extremity; and pelvis) were rated for this examination. Range of motion measurements were required in this case. The original claim form was properly coded and submitted in a timely fashion to the carrier.

Amount in Dispute: \$300.00

Respondent's Position

Dr. Smith was entitled to \$950 for this date of service since he found the claimant to be at MMI and assigned impairment for up to three body parts. A finding of MMI entitled Dr. Smith to \$350.00. The impairment for the spine/pelvis was based on DRE was \$150.00. Impairment for the upper extremity based on the first range of motion exam was \$300. Reimbursement for assigning impairment for the subsequent range of motion exam of the lower extremities was \$150.00. This totals \$950.00.

Dr. Smith was initially paid \$800 for this date of service. This was based on entitlement to \$350 for the MMI evaluation plus up to three body parts of \$450. A subsequent payment was issued in the amount of \$300 to try and resolve this matter.

Response submitted by: White Espey

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 §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. 28 TAC §134.240 sets out the guidelines for designated doctor exams.

Denial Reasons

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

- P12 – Workers' compensation jurisdictional fee schedule adjustment
- 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.201(J) for attainment of maximum medical improvement. An additional allowance is payable if a determination of the impairment caused by the compensable injury was also performed
- W3 – Additional payment made on appeal/reconsideration
- 556 – Based on the receipt of additional information and/or clarification, we are recommending further payment be made for the above noted procedure code(s).

Issues

1. Is the insurance carrier’s reduction based on fee schedule supported?

Findings

1. The requestor is seeking additional reimbursement for Code 99456 W5 WP of \$300.00.

According to 28 TAC §§134.250 (3)(C) and 134.240 (1)(B), the examining doctor is required to bill an examination to determine maximum medical improvement with CPT code 99456 and modifier “W5.” The submitted documentation supports that Dr. Smith performed an evaluation of maximum medical improvement as ordered by DWC. 28 TAC §134.250 (3)(C) states that the maximum allowable reimbursement (MAR) for this examination is \$350.00.

When the examining doctor calculates an impairment rating, 28 TAC §§134.250 (4)(A) and 134.240 (1)(A) require the doctor to bill with CPT code 99456 and modifier “W5.” When the examining doctor also performs the testing for impairment rating of musculoskeletal body areas, 28 TAC §134.250 (4)(C)(iii) requires the examining doctor to add modifier “WP.”

Review of the submitted documentation finds that Dr. Smith performed impairment rating evaluations of spine and pelvis, upper extremities (shoulder), lower extremities including foot.

DWC Rule 28 TAC §134.250 (4)(C) defines the fees for the calculation of an impairment rating for musculoskeletal body areas. The MAR for the evaluation of the first musculoskeletal body area performed with range of motion is \$300.00.

The MAR for the evaluation of subsequent musculoskeletal body areas is \$150.00 each.

The total MAR for the determination of maximum medical improvement and impairment rating is \$950.00. The insurance carrier paid \$1,100.00. No additional payment 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

February 11, 2022

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 electrónico CompConnection@tdi.texas.gov.