



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Clenney, Kelly D

**Respondent Name**

AIU Insurance Co

**MFDR Tracking Number**

M4-22-1851-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

April 27, 2022

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 23, 2022	99456 WP W5	\$150.00	\$0.00
<b>Total</b>		\$150.00	\$0.00

### Requestor's Position

Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of adjudication.

**Amount in Dispute:** \$150.00

### Respondent's Position

While the Provider is correct that he is entitled to an additional \$150, he has already been over compensated for the other parts of his bill... The initial EOR dated April 8, 2022, reimbursed the Provider \$500 for both the extent of injury exam and for the direct result of disability exam. ...the Provider should have reimbursed \$800 for the MMI and impairment rating exam, \$500 for the extent of injury exam and \$250 for the direct result of disability exam which would total \$1,550. The Provider has already been paid \$1,650.00

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

### Denial Reasons

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

- 309 – The charge for this procedure exceeds the fee schedule allowance
- 5141 – Bill has been reviewed by a nurse or under the direction of a nurse
- P12 – Workers' compensation jurisdictional fee schedule adjustment

### Issues

1. Is the requestor due an additional reimbursement?

### Findings

1. The requestor is seeking additional reimbursement of \$150.00 for designated doctor services rendered March 23, 2022. The respondent states in their position statement, "...the Provider should have reimbursed \$800.00 for the MMI and impairment rating exam, \$500 for the extent of injury exam and \$250 for the direct result of disability exam which would total \$1,550. The Provider has already been paid \$1,650.00." Review of the applicable fee guideline for codes 99456 WP W5, 99456 RE W6, 99456 RE W7 is found below.

99456 WP W5

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." The reimbursement is \$350.00.

Review of the submitted documentation finds the Doctor performed impairment rating evaluations of cervical spine and right shoulder with range of motion testing. The rule at 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 impairment rating is  $(\$350.00 + \$300.00 + \$150.00) = \$800.00$ .

99456 RE W6

The designated doctor is required to bill an examination to determine extent of injury with CPT code 99456 and modifier "RE." 28 TAC §134.210(e)(21) states in pertinent part, W6 – designated doctor examination for extent.

The submitted documentation indicates that Doctor performed an examination to determine extent of injury. According to 28 TAC §134.235, the MAR for this examination is \$500.00.

99456 RE W7

The designated doctor is required to bill an examination to determine extent of injury with CPT code 99456 and modifier "RE." The submitted documentation indicates the Doctor performed examination to determine disability. 28 §134.210(e)(22) states in pertinent part W7 – designated doctor examination for disability.

DWC Rule 28 TAC §134.235, states in pertinent part, The MAR not including maximum medical improvement and impairment rating, when multiple examinations of this type are required, the first examination is reimbursed at 100% the second examination is reimbursed at 50%. This is the second examination the MAR allowable is \$250.00,

For this dispute the total MAR is  $(\$800.00 + \$500.00 + \$250.00)$  or \$1,550.00. Review of the submitted explanation of benefits found the insurance carrier paid \$1,650.00 on April 12, 2022 via check number 91027691. 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

\_\_\_\_\_  
June 8, 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).