TDI Division of Workers' Compensation
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Amended Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
JAY M. HARRISON, DC

Respondent Name
ZNAT INSURANCE COMPANY

MFDR Tracking Number
M4-22-2754-02

Carrier's Austin Representative
Box Number 47

DWC Date Received
August 25, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 18, 2022	99456-W5-WP	$650.00	$650.00

Requestor's Position

"CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS".

Amount in Dispute: $650.00

Respondent's Position

"Upon receipt of the MFDR, Zenith reviewed the payment history for the claimant and identified that the provider submitted the original bill submission with the MFDR. Our records indicate that Zenith received only the report from the provider, but not the billing form. The date of service is 02/18/2022, 95 days from the date of service is 05/24/2022. Therefore, the original bill submitted with the MFDR has been denied in its entirety pursuant to Rule 133.20(b). The EOP will advise the provider of the adjustment."

Response Submitted by: The Zenith

Amended Findings and Decision

Authority

By Official Order Number 6695 dated February 26, 2021, the undersigned has been delegated authority by the Commissioner to **amend** fee dispute decisions.

This **amended** findings and decision supersedes all previous decision rendered in this medical payment dispute involving the above requestor and respondent.

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.210, effective July 7, 2016, provides the medical fee guideline for division specific services.
3. 28 TAC §134.235, effective July 7, 2016, sets the reimbursement guidelines for return-to-work evaluations.
4. 28 TAC §134.240, effective July 7, 2016, sets the reimbursement guidelines for Designated Doctor Examinations.
5. 28 TAC §134.250, effective July 7, 2016, sets the reimbursement guidelines for Maximum Medical Improvement Evaluations and Impairment Rating Examinations.
6. 28 TAC §133.250, sets out the guidelines for reconsideration for payment of medical bills.
7. 28 TAC §133.240, sets out the guidelines for medical payments and denials.

Denial Reasons

Neither party to the dispute submitted any explanation of benefits to support the denial of payment for services.

Issues

1. Did the requestor submit sufficient documentation to support that a medical bill was submitted to the insurance carrier prior to the filing of the Medical Fee Dispute resolution request?
2. What rules apply to the reimbursement of CPT 99456-W5-WP?
3. Is the requestor entitled to reimbursement for the service in dispute?

Findings

1. The requestor seeks reimbursement for a designated doctor examination, billed under CPT 99456-W5-WP and rendered on February 18, 2022. Review of the documentation submitted by both parties finds that neither party submitted copies of explanation of benefits (EOBs).

   28 TAC §133.240 (a) states, "(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a result of a pending request for additional documentation."

   28 TAC §133.250 (c) (2) states, "(c) A health care provider shall not submit a request for reconsideration until…(2) the health care provider has not received an explanation of benefits within 50 days from submitting the medical bill to the insurance carrier."

   The DWC finds that the requestor submitted sufficient documentation in the form of fax confirmations of eight pages to support that the medical bills were faxed to the insurance carrier on March 3, 2022 and a reconsideration on May 27, 2022. The insurance carrier's response states that "our records indicate that Zenith received only the report from the provider, but not the billing form." Zenith confirmed they did receive a fax from the requestor, and the report, DWC069, and fax cover sheet submitted with the requestor's dispute packet were a total of seven pages. While not confirming that the eighth page of the fax confirmations was the medical bill, DWC finds that the greater weight of evidence supports timely submission of the medical bill. As a result, the dispute is eligible for Medical Fee Dispute resolution review and is reviewed pursuant to the applicable rules and guidelines.

2. To determine the appropriate reimbursement the division refers to the following:

   28 TAC §134.210(b)(2) states, "Modifying circumstance shall be identified by use of the appropriate modifier following the appropriate Level I (CPT codes) and Level II HCPCS codes. Where HCPCS modifiers apply, insurance carriers shall treat them in accordance with Medicare and Texas Medicaid rules. Additionally, division-specific modifiers are identified in subsection (e) of this section. When two or more modifiers are applicable to a single HCPCS code, indicate each modifier on the bill."

   28 TAC §134.240(1)(A)(B) states, "Designated doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041, and 408.151 and division rules, and shall be billed and reimbursed as follows: (A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with §134.250 of this title, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor; (B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with §134.250 of this title, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor."

28 TAC §134.250(4)(C)(iii) states, "If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier 'WP.' Reimbursement shall be 100 percent of the total MAR." A review of the submitted medical bill finds the requestor billed for the Designated Doctor evaluation using code 99456 with modifier "W5" and "WP."

28 TAC §134.250(3)(C) states, "The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT code 99456. Reimbursement shall be $350." Because the requestor performed the MMI evaluation in accordance with the division order; the requestor is due $350.00.

28 TAC §134.250 (4)(C)(i)(III) states, "The following applies for billing and reimbursement of an IR evaluation. (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (i) Musculoskeletal body areas are defined as follows: (III) Lower extremities (including feet).

28 TAC §134.250 (4)(C)(ii)(II) states, "The MAR for musculoskeletal body areas shall be as follows: (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." The requestor wrote that a full range of motion IR evaluation was performed on the lower extremities; therefore, the requestor is due $300.00.

3. The DWC finds that the requestor is entitled to reimbursement in the amount of $650.00. Therefore, this amount 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.

The DWC finds the requester has established that reimbursement of $650.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the Respondent must remit to the Requestor $650.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		November 10, 2022
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 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.