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

General Information

Requestor Name
David M. Griffith, D.C.

Respondent Name
Accident Fund General Insurance

MFDR Tracking Number
M4-24-0170-01

Carrier's Austin Representative
Box Number 06

DWC Date Received
September 20, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 23, 2023	Designated Doctor Examination 99456-W5-WP 99456-W6-RE 99456-W8-RE	$500.00	$0.00

Requestor's Position

"Reimbursement for Multiple Designated Doctor Examinations Under the Same Division Order

1) W5 RE 2 units $800.00

2) W6 RE 2 units $500.00

3) W8 RE 2 units $250.00
   Total Reimbursement $1550.00
   Insurance Payment: $1050.00

Please pay the remaining balance of $500.00."

Amount in Dispute: $500.00

Respondent's Position

"Requestor sought payment for a Designated Doctor examination and billed with modifiers W5, W6, and W8 … Accident Fund paid Requestor for modifiers W5 and W8. Accident Fund did not pay requestor for W6 (extent of injury) because the Designated Doctor did not address the extent of the injury."

Response Submitted by: Stone Loughlin Swanson

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable 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 §134.235 sets out the fee guidelines for examinations to determine ability to return to work and extent of injury.

3. 28 TAC §134.240 sets out the fee guidelines for designated doctor examinations.

4. 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 payment for the disputed services with the following claim adjustment codes:

- G74 – Requested documentation to support the bill was absent or incomplete.
- @G(W3) – No additional reimbursement allowed after review of the appeal/reconsideration.
- YO(P12) – Denial After Reconsideration
- TX P12 – Workers' compensation jurisdictional fee schedule adjustment.
- TX W3 – The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.

Issues

1. Is David M. Griffith, D.C. entitled to reimbursement for the examination in question?

Findings

1. Dr. Griffith is seeking reimbursement for a designated doctor examination billed with procedure codes 99456-W5-WP, 99456-W6-RE, and 99456-W8-RE.

   28 TAC §134.250(3)(C) states, "An examining doctor, other than the treating doctor, shall bill using CPT code 99456. Reimbursement shall be $350."

   28 TAC §134.240(1)(B) states, "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."

   The submitted documentation supports that Dr. Griffith performed an evaluation of maximum medical improvement (MMI) as ordered by the DWC. This examination was billed with procedure code and modifiers 99456-W5-WP. The maximum allowable reimbursement (MAR) for this examination is $350.00.

   28 TAC §134.250(4) states, "The following applies for billing and reimbursement of an IR evaluation. (A) The health care provider shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the unit's column of the billing form."

   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."

   28 TAC §134.240(1)(A) states, "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."

   Review of the submitted documentation finds that Dr. Griffith performed impairment rating evaluations of upper extremities and lower extremities with range of motion testing. This examination was billed with the MMI portion of the examination under procedure code and modifiers 99456-W5-WP for two units.

   28 TAC §134.250(4)(C) 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; and (-b-) $150 for each additional musculoskeletal body area."

   The MAR for the evaluations to determine impairment rating in this examination is $450.00.

   28 TAC §134.235 states, in relevant part, "When conducting a division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier 'RE.' In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title and shall include division-required reports."

28 TAC §134.240 defines modifiers used with examinations exclusive to designated doctors. It states, in relevant part,

(1) 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: …

(C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier 'W6';

(D) Whether the injured employee's disability is a direct result of the work-related injury shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier 'W7';

(E) Ability of the employee to return to work shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier 'W8'; and

(F) Issues similar to those described in subparagraphs (A) - (E) of this paragraph shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier 'W9.'

28 TAC §134.240(2) states, in relevant part, "When multiple examinations under the same specific division order are performed concurrently under paragraph (1)(C) - (F) of this section: (A) the first examination shall be reimbursed at 100 percent of the set fee outlined in §134.235 of this title; (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in §134.235 of this title."

Dr. Griffith billed $500.00 for procedure code 99456-W6-RE and $250.00 for procedure code 99456-W8-RE. The submitted documentation indicates that Griffith performed an examination to determine the ability to return to work. Therefore, Dr. Griffith is entitled to reimbursement for the billed amount of $250.00. No evidence was found to support that Dr. Griffith performed an examination to determine the extent of the compensable injury. No reimbursement can be recommended for this service.

The total allowable reimbursement for the services in question is $1,050.00. Per explanation of benefits dated July 6, 2023, the insurance carrier paid this amount. No additional reimbursement 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 requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 30, 2023 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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.