



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

RMJ EVALUATIONS
JOHN D. KIRKWOOD, DO

Respondent Name

ASSOCIATION CASUALTY INSURANCE

MFDR Tracking Number

M4-12-0950-01

Carrier's Austin Representative

Box Number 53

MFDR Date Received

NOVEMBER 23, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This billing was for a designated doctor's evaluation assigned by the Texas Department of Insurance Division of Workers' Compensation."

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary dated December 5, 2011: "TDI-DWC has determined the requestor was not appointed to serve as a designated doctor in accordance with Tex.Lab.Code 408.0041 and DWC rule 127.5. Enclosed please find amount other documents, the D&O mailed to all parties October 4, 2011 which includes said finding. As a result, the Carrier has no liability for the requestor's date of service."

Response Submitted by: Hoffman Kelley

SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|------------------|---|-------------------|------------|
| July 28, 2011 | CPT Code 99456-W5-WP-MI Designated Doctor Evaluation | \$650.00 | \$650.00 |

FINDINGS AND DECISION

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

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 201-WC case settled. Patient is responsible for amount of this claim/service through WC Medicare set-aside or other arrangement.
 - W2-Workers' compensation claim adjudicated as non-compensable. Carrier not liable for claim or service/treatment.

Issues

1. Was the Designated Doctor Examination (DDE) ordered by the Division?
2. Did the Designated Doctor bill for the MMI/IR evaluation in accordance with medical fee guideline?
3. Is the requestor entitled to reimbursement?

Findings

1. On June 22, 2011, the Division ordered a second DDE with Dr. Kirkwood to determine MMI/IR. The claimant initially had a DDE with Dr. David Tasker that found claimant had reached MMI on February 24, 2010 with a 22% impairment for injury to the right eye. After the initial DDE the claimant's right ankle fracture was found to be compensable by Decision and Order dated March 4, 2011. The Division then ordered the DDE that was performed on July 28, 2011.
2. On the disputed date of service the requestor billed CPT code 99456-W5-WP.

- 28 Texas Administrative Code §134.204(i)(1)(A) states "The following shall apply to Designated Doctor Examinations. (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: (A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier "W5" is the first modifier to be applied when performed by a designated doctor"

A review of the submitted medical billing finds that the requestor billed modifier "W5" as the first modifier appended to CPT code 99456.

- 28 Texas Administrative Code §134.204(j)(3) 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."

The requestor billed CPT code 99456 because the examination was performed by a designated doctor.

- 28 Texas Administrative Code §134.204(j)(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 Texas Administrative Code §134.204(n)(18) states "The following Division Modifiers shall be used by HCPs billing professional medical services for correct coding, reporting, billing, and reimbursement of the procedure codes. The "WP" modifier is defined as "Whole Procedure--This modifier shall be added to the CPT code when both the professional and technical components of a procedure are performed by a single HCP."

A review of the requestor's billing finds that the "WP" modifier was appended to CPT code 99456 to designate that the provider had performed the MMI examination and the IR testing.

The Division finds that the Designated Doctor billed for the evaluation/examination in accordance with 28 Texas Administrative Code §134.204; therefore, reimbursement is recommended.

3. The maximum allowable reimbursement (MAR) for CPT code 99456-W5-WP is:
 - 28 Texas Administrative Code §134.204(j)(1) states "Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:
 - (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR.
 - 28 Texas Administrative Code §134.204(j)(4)(C) states "For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas."
 - 28 Texas Administrative Code §134.204(j)(4)(C)(ii) states "The MAR for musculoskeletal body areas shall be as follows.
 - (i) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.

- (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.”

A review of the Designated Doctor report finds that a full evaluation with range of motion was performed on the right ankle; therefore, the MAR is \$300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a). Per 28 Texas Administrative Code §134.204(j)(3)(C) the requestor is due \$350.00 for the MMI evaluation. Therefore, the total allowable for the MMI/IR evaluation is \$650.00. The respondent paid \$00.00. As a result, the requestor is entitled to reimbursement of \$650.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$650.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

| | | |
|-----------|--|------------|
| _____ | _____ | 11/13/2014 |
| Signature | Medical Fee Dispute Resolution Officer | Date |

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.