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 and Address

MARCUS HAYES DC
PO BOX 198
BAKER TX 77413-0198

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box
Box Number 54

MFDR Tracking Number
M4-12-1135-01

MFDR Date Received

December 12, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I submitted a properly completed, properly documented claim to Texas Mutual Ins. Co. Payment by the IC was denied due to: … In response, I submitted a request for reconsideration which included the rules for billing MMI & IR. The IC's response included denial of reimbursement again due to: … Regarding the denial in payment, the CPT code and the modifier, 99456-WP, was billed correctly. The Texas Department of Insurance's Division of Workers' Compensation (TDI-DWC) fee guidelines dictate that an Impairment Evaluation in which **MMI and IR are performed** is reimbursed as follows: … Therefore, AI&FATC requests Texas Mutual Ins. Co. to remit the **balance due to $500.00 plus interest** for said procedure performed on said patient on said date."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor performed a functional evaluation of the claimant on 8/30/11 then billed Texas Mutual code 97750-FC for this. (Attachment)

2. The treating doctor asked the requestor to conduct MMI/IR exams, which the requestor carrier out on 10/25/11 then billed Texas Mutual for this with code 99456-WP. (See requestor's DWC-60 packet.)

3 . Rule 134.204 at (3)A)(B) states if the treating doctor refers the claimant to another doctor for MMI/IR and that doctor has previously treated the claimant then the referral doctor is to bill the MMI evaluation, consistent with paragraph (3)(A), with code 99455 and with modifiers "V1", "V2", "V3", "V4", or "V5" as applicable."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2011	CPT Code 99456-WP	$500.00	$0.00

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

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 18, 2011

   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CAC-4 – THE PROCEDURE CODE IS INCOSISTENT WITH THE MODIFIER USED OR A REQUIRED IS MISSING
   - 714 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. CPT/HCPSCS BILLED INCORRECLTY. SERVICES ARE NOT REIMBURSABLE AS BILLED
   - 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. MODIFIER BILLED INCORRECLTY OR MISSING. SERVICES ARE NOT REIMBURSEABLE AS BILLED

   Explanation of benefits dated December 06, 2011

   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
   - CAC-4 – THE PROCEDURE CODE IS INCOSISTENT WITH THE MODIFIER WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING
   - 714 – ACCURATE CODING IS ESSENTIAL FOR RIEMBURSEMENT, CPT/HCPCS BILLED INCORRECLTY. SERVICES ARE NOT REIMBURSABLE AS BILLED
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
   - 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. MODIFIER BILLED INCORRECLTY OR MISSING. SERVICES ARE NOT REIMBURSABLE AS BILLED

Issues

1. Is the disputed CPT Code 99456 billed appropriately?
2. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Requestor billed with CPT Code 99456 WP in the amount of 500.00 with one unit billed.

   Per 28 Administrative Code §134.204 states: " (j) 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. The MMI/IR examination shall include, (C) If the examining doctor determines MMI has been reached and an IR evaluation is performed, both the MMI evaluation and the IR evaluation portions of the examination shall be billed and reimbursed in accordance with paragraphs (3) and (4) of this subsection, (3) The following applies for billing and reimbursement of an MMI evaluation, (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier, (i) Reimbursement shall be the applicable established patient office visit level associated with the examination, (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit, (B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has, (i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this subsection; or,

   (4) The following applies for billing and reimbursement of an IR evaluation, (A) The HCP 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 units column of the billing form, (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: (I) spine and pelvis; (II) upper extremities and hands; and, (III) lower extremities (including feet), (ii) 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 or (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.

In review of the submitted documentation findings is a DWC-69 supporting an examination held on October 25, 2011 to address the following issues of Maximum Medical Improvement (MMI) and Impairment Rating (IR) with two body areas being rated using the Diagnosis Related Estimate (DRE) method.

Therefore, CPT Code 99456-WP is not supported according to the documentation provided as well as the services billed are inconsistent to what the RME report indicates.

2. The respondent issued payment in the amount of $0.00. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that no additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		3/17/14
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it 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.