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
HOBERT SMITH, MD

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-12-1680-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
JANUARY 18, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This letter is in response to the EOB received regarding the denial of payment for the Designated Doctor Examination and Nerve Study provided by Dr. Hobert Smith MD 09-19-11. ..We are respectfully requesting your reconsideration and payment of this examination which your company requested and our doctor provided in good faith."

Amount in Dispute: $956.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a response to this request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 19, 2011	CPT Code 99456-W6-WP	$150.00	$150.00
	CPT Code 95903-TC (X6)	$160.00	$0.00
	CPT Code 95904-TC	$160.00	$0.00
	CPT Code 95900-TC	$256.00	$0.00
	CPT Code 95934-TC	$80.00	$0.00
	CPT Code 95861-TC Needle EMG	$150.00	$0.00
TOTAL		$956.00	$150.00

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 resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. Former 28 Texas Administrative Code §130.6 effective January 1, 2007, refers to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings.
4. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the rule for medical bill submission by a Health Care Provider.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 216-Based on the findings of a review organization.
   - X334-Unnecessary medical treatment and or service per peer review documentation attached.
   - Z656-Any request for reconsideration of this workers' compensation payment should be accompanied by a copy of this explanation of review.
   - 150-Payer deems the information submitted does not support his level of service.
   - VF01-Documentation does not support level of service billed.
   - W1-Workers compensation state fee schedule adjustment.
   - VRNA-No reduction available.
   - Z710-The charge for this procedure exceeds the fee schedule allowance.
   - 18-Duplicate claim/service.
   - U301-This item was previously submitted and reviewed with notification of decision issued to payor.

The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on January 20, 2012. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

Issues

1. Does a medical necessity issue exist in this dispute?
2. Did the Designated Doctor bill for the Extent of Injury evaluations in accordance with medical fee guideline?
3. Is the requestor entitled to additional reimbursement for CPT code 99456-W6-WP?
4. Does the documentation support technical billing of NCV/EMG?

Findings

1. According to the submitted explanation of benefits, the respondent initially denied reimbursement for the disputed services based upon not medically necessary. Upon reconsideration, the respondent did not maintain this denial and issued payment of $350.00 for the Designated Doctor examination and denied payment for the testing based upon the documentation did not support the services billed. The Division finds that a medical necessity issue does not exist in this dispute.

2. On the disputed date of service the requestor billed CPT codes 99456-W6-WP.

   - 28 Texas Administrative Code §134.204(i)(1)(C) 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: (C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier 'W6;'
   - 28 Texas Administrative Code §134.204(n)(21) defines the "W6" modifier as "Designated Doctor Examination for Extent--This modifier shall be added to the appropriate examination code performed by a designated doctor when determining extent of the employee's compensable injury."

   A review of the submitted medical billing finds that the requestor billed modifier "W6" for the extent of injury examination.

3. The maximum allowable reimbursement (MAR) for CPT codes 99456-W6 is:

   - 28 Texas Administrative Code §134.204(k) states "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. 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 MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

   Per 28 Texas Administrative Code §134.204(k), the total allowable is $500.00 for the extent of injury evaluation. The respondent paid $350.00. As a result, the requestor is due the difference of $150.00.

4. The respondent denied reimbursement for the testing billed with CPT code 95903-TC, 95904-TC, 95900-TC, 95934-TC and 95861-TC based upon reason codes "150", and "VF01". The requestor appended modifier "TC-Technical Component" to the NCV/EMG codes.

   - 28 Texas Administrative Code §134.204(k) states that "Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

   The requestor noted on the Medical Evaluation Report Summary that "DWC Rule 130.06(e) allows for the designated doctor to request any test necessary to complete the examination. We have order a NCV/EMG with Dr. Martinez DC to determine whether her radiating symptoms in her left leg can be verified."

   28 Texas Administrative Code §133.20(e)(2) states "A medical bill must be submitted: in the name of the licensed health care provider that provided the health care or that provided direct supervision of an unlicensed individual who provided the health care."

   The Division reviewed the submitted medical records and supporting documentation and finds the following:

   - Dr. Hobert L. Smith is listed in box 31 of the medical bill as the physician or supplier.
   - Dr. Smith's report indicates that claimant was referred to Dr. Martinez for the NCV/EMG.
   - The Advanced Neuro Diagnostic report dated September 21, 2011 indicates that Dr. Perez referred the claimant and that the technician was Scott Dinkens. No documentation was submitted to support that Scott Dinkens was an unlicensed individual providing the technical services that required Dr. Smith's supervision per 28 Texas Administrative Code §133.20(e)(2).
   - The Lonestar Neuro Diagnostic & Rehab report dated September 21, 2011 indicates that the referring physician is Dr. Smith and that the technician was Dr. Martinez. No documentation was submitted to support that Dr. Martinez was an unlicensed individual providing the technical services that required Dr. Smith's supervision per 28 Texas Administrative Code §133.20(e)(2).
   - Both the Advanced Neuro Diagnostic report and The Lonestar Neuro Diagnostic & Rehab report indicate that testing was performed on September 21, 2011; however, the date listed on the submitted medical bill is September 19, 2011. No documentation was submitted to support the disputed testing was performed on September 19, 2011, the date on the submitted bill.
   - No documentation was submitted to support Dr. Hobert performed the technical component for the disputed testing.

   The Division concludes that the submitted documentation does not support billed service. As a result, no reimbursement is recommended for the testing.

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 $150.00.

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 $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		10/24/2014
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.