



**TEXAS DEPARTMENT OF INSURANCE**

**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**

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**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

STEPHEN J. RINGEL, MD

**Respondent Name**

INDEMNITY INSURANCE CO OF NORTH AMERICA

**MFDR Tracking Number**

M4-18-3983-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

JUNE 13, 2018

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** This claim was initially submitted on 12/21/2017 and an email sent to the adjuster with claim in February. No response has been received, either denial or payment. Dr. Ringel performed this designated doctor exam at the request of TDI Div of Worker's Comp. We believe payment is due."

**Amount in Dispute:** \$650.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "Supplemental response will be provided once the bill auditing company has finalized their review."

**Response Submitted By:** Gallagher Bassett Services

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2017	CPT Code 99456-W5-WP 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**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.210, effective July 7, 2016, provides the medical fee guideline for division specific services.
3. 28 Texas Administrative Code §134.240, effective July 7, 2016, sets the reimbursement guidelines for Designated Doctor Examinations.
4. 28 Texas Administrative Code §134.250, effective July 7, 2016, sets the reimbursement guidelines for

Maximum Medical Improvement Evaluations and Impairment Rating Examinations.

5. Neither party submitted any Explanation of Benefits to support the rationale for denial of payment for the disputed services.

### **Issues**

Is the requestor due reimbursement of \$650.00 for code 99456-W5-WP?

### **Findings**

1. The Division ordered the claimant to attend a Designated Doctor evaluation with Dr. Ringel to determine MMI/IR. The requestor states, "This claim was initially submitted on 12/21/2017 and an email sent to the adjuster with claim in February. No response has been received, either denial or payment. Dr. Ringel performed this designated doctor exam at the request of TDI Div of Worker's Comp. We believe payment is due."

2. To determine if reimbursement is due the division refers to the following statute:

28 Texas Administrative Code §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 Texas Administrative Code §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 Texas Administrative Code §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 Texas Administrative Code §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."

28 Texas Administrative Code §134.250 (4)(C) 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."

28 Texas Administrative Code §134.250 (4)(C)(ii)(II) states, "The MAR for musculoskeletal body areas shall be as follows: If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area."

28 Texas Administrative Code §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."

3. The division finds the following based upon the submitted documentation and above referenced statute:
  - The division ordered the claimant to attend a MMIR/IR evaluation with the requestor.
  - The requestor performed the MMI/IR on December 12, 2017.
  - The requestor billed for the MMIR/IR in accordance with 28 Texas Administrative Code §134.240(1)(A)(B) and §134.250(3) and (4).
  - The report supports the billed service.
  - The requestor is due reimbursement of \$650.00.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that 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**

		8/30/2018
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 in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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