



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

LUTHER BRATCHER, DC

Respondent Name

PHOENIX INSURANCE CO

MFDR Tracking Number

M4-18-4492-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

July 26, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Provider billed \$650.00 for 1 unit CPT code 99456-W5-WP...the Carrier reimbursed the Provider \$350.00 for the Maximum Medical Improvement evaluation per Rule 134.250(3)(C), and \$150.00 for the DRE impairment rating assignment per Rule 134.250(4)(C) and (D). The Provider alleges they are entitled to additional reimbursement of \$150.00 for the IR evaluation, but provides no rationale for that position."

Response Submitted By: Atty. William E. Weldon/Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 20, 2018	CPT Code 99456-W5-WP Designated Doctor Evaluation	\$150.00	\$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 §134.210, 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. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 309-The charge for this procedure exceeds the fee schedule allowance.
 - P12-Workers' compensation jurisdictional fee schedule adjustment.

Issues

Is the requestor due additional reimbursement of \$150.00 for code 99456-W5-WP?

Findings

1. On the disputed date of service, the requestor billed \$650.00 for CPT code 99456-W5-WP. The respondent paid \$500.00 based upon the fee guideline. The respondent contends that additional reimbursement is not due because, "the Carrier reimbursed the Provider \$350.00 for the Maximum Medical Improvement evaluation per Rule 134.250(3)(C), and \$150.00 for the DRE impairment rating assignment per Rule 134.250(4)(C) and (D)."
2. To determine if additional 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 requestor is seeking additional reimbursement of \$150.00 for the ROM impairment rating. The division finds that the requestor did support a full examination with range of motion studies. As a result, additional reimbursement of \$150.00 is recommended.

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 \$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

		8/27/2018
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.