



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

BILL J. MATHIAS, MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-18-4755-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

AUGUST 6, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting full payment for the medical services performed."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed \$800.00; for 99456-WP. Texas Mutual paid \$350.00 for the MMI exam and \$300.00 for IR of the knee. No additional payment was made for the IR of the spine due to the requestor's failure to bill 2 units in Box 24G on his CMS-1500 form. No additional payment is due."

Response Submitted By: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 20, 2018, CPT Code 99456-WP Designated Doctor Evaluation, \$150.00, \$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 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:

- A15-The reimbursement for health care services are subject to Texas Star Network Contracts, a certified WC HCN (Ins Code CH. 1305).
- CAC-45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
- 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
- CAC-P12-Workers' compensation jurisdictional fee schedule adjustment.

## Issues

Is the requestor due additional reimbursement for code 99456-WP?

## Findings

1. On the disputed date of service, the requestor billed \$800.00 for CPT code 99456-WP. The respondent wrote, "Texas Mutual paid \$350.00 for the MMI exam and \$300.00 for IR of the knee. No additional payment was made for the IR of the spine due to the requestor's failure to bill 2 units in Box 24G on his CMS-1500 form. No additional payment is due."

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 reimbursement for an additional impairment rating. The division finds that the requestor did not bill for the MMI/IR as outlined in 28 Texas Administrative Code §134.240(1)(A)(B) because they did not use the appropriate modifiers or the number of units rated. As a result, additional reimbursement is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

**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**

		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.**