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
SMITH, EDWARD WILLIAM

Respondent Name
SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number
M4-21-0988-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
February 23, 2021

REQUESTOR'S POSITION SUMMARY

"**Three body areas were rated for this examination.** Range of motion measurements were required in this case."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

"The previous review is being maintained (Payment of $650.00) and no additional allowance is recommended … In our review of TAC per TAC Rule 134.240 for Designated Doctor and 134.250 for MMI Evaluations and IR Exam only one 99456-W5-WP per visit would be reimbursable for the services submitted."

Response Submitted by: Mitchell International, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 23, 2020	Designated Doctor Examination (99456-W5-WP)	$300.00	$300.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. Texas Labor Code §408.0041 sets out the requirements for designated doctor examinations.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 308 – MMI/IR procedure code 99456 is permitted only once on the same date of service.
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.
   - 18 – Exact duplicate claim/service
   - 350 – Bill has been identified as a request for reconsideration or appeal.

- 756 – Per Rule 133.250 provider may not submit reconsideration after the carrier has taken final action. Seek MDR in accordance to Rule 133.307.

Issues

1. Is the examination in question subject to dismissal based on medical necessity?
2. Is Edward W. Smith, D.O. entitled to additional reimbursement?

Findings

1. Dr. Smith is seeking additional reimbursement for an examination to determine maximum medical improvement (MMI) and impairment rating (IR) ordered by the DWC. Service Lloyds Insurance Company denied payment based, in part, on medical necessity.

   The insurance carrier is required to reimburse designated doctor examinations unless otherwise prohibited by statute, order, or rule.[1] The insurance carrier submitted no evidence to support that reimbursement for the examination in question was prohibited. The DWC finds that the examination in question is not subject to dismissal based on medical necessity.

2. The designated doctor is required to bill an examination to determine maximum medical improvement with CPT code 99456 and modifier "W5."[2] The submitted documentation supports that Dr. Smith performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[3]

   The designated doctor is required to bill an examination to determine the impairment rating of an injury with CPT code 99456 and modifier "W5."[4] Review of the submitted documentation finds that Dr. Smith performed impairment rating evaluations of a cervical strain and the right shoulder with range of motion testing, scalp laceration and contusion, left forearm abrasion, and a chondro-sternum joint sprain.

   The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[5] The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each.[6] The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.[7] The total MAR for the determination of impairment rating is $750.00.

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]		$350.00
IR: Left Shoulder (ROM)	Musculoskeletal System	Upper Extremities	$300.00
IR: Cervical Strain (ROM)		Spine and Pelvis	$150.00
IR: Scalp laceration/contusion	Skin	Body Structures	$150.00
IR: Left Forearm Abrasion			
IR: Chondro-Sternum Joint Sprain	Respiratory System	Body Systems	$150.00
Total MMI	[redacted]		**$350.00**
Total IR			**$750.00**
Total Exam			**$1,100.00**

   The insurance carrier paid $650.00. Dr. Smith is seeking $300.00. This amount is recommended.

[1] TLC §408.0041 (h)
[2] 28 TAC §§134.250(3)(C) and 134.240(1)(B)
[3] 28 TAC §134.250(3)(C)
[4] 28 TAC §§134.250(4)(A) and 134.240(1)(A)
[5] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[6] 28 TAC §134.250(4)(C)(ii)(II)(-b-)
[7] 28 TAC §134.250(4)(D)(v)

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $300.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		May 6, 2021
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 Rule §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed, or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **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.