TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
John Sklar, M.D.

Respondent Name
Travelers Casualty & Surety Co.

MFDR Tracking Number
M4-24-1705-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
April 5, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 19, 2022	Designated Doctor Examination 99456-W5-WP	$150.00	$150.00
	Designated Doctor Examination 99456-W5-SP	$50.00	$50.00
	Designated Doctor Examination 99456-W6-RE	$0.00	$0.00
	Designated Doctor Examination 99456-W8-RE	$0.00	$0.00
	Total	$200.00	$200.00

Requestor's Position

"THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: $200.00

Respondent's Position

"For CPT 99456-W5-WP, the Provider was reimbursed $350 for the Maximum Medical Improvement evaluation, $300 for the range of motion evaluation of the upper extremities, and $150 for the range of motion evaluation for the lower extremities. For CPT 99456-W5-SP, the Designated Doctor performed the range of motion testing himself and did not assign any

impairment based on the evaluation from the referral evaluation. Consequently, there were no evaluations to incorporate into this report pursuant to Rule 134.250(4)(D)(iii)(I). The Provider has been appropriately reimbursed for the disputed CPT codes, and no additional reimbursement is due."

Response Submitted by: Travelers

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed.
- 3244 – The billing of the procedure code has exceeded the National Correct Coding Initiative Medically Unlikely Edits amount for the number of times this procedure can be billed on a date of services. An allowance has not been paid.

Issues

1. What services are considered in this dispute?

2. Are Travelers Casualty & Surety Co.'s denials of payment for procedure code 99456-W5-SP supported?

3. Is John Sklar, M.D. entitled to additional reimbursement?

Findings

1. Dr. Sklar is seeking reimbursement for a designated doctor examination to determine maximum medical improvement, impairment rating that incorporated a specialist's report, extent of the compensable injury, and ability to return to work.

   Dr. Sklar is seeking $0.00 for the examinations to determine the extent of the compensable injury and ability to return to work. Therefore, these services are not considered in this dispute.

   He is seeking an additional $200.00 for the examination to determine maximum medical improvement and impairment rating, and the incorporation of a specialist's report. These services are considered in this dispute.

2. Payment for procedure code 99456-W5-SP, which was billed for incorporating a specialist's report was denied for the following reasons:

   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated,
   - 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed, and
   - 3244 – The billing of the procedure code has exceeded the National Correct Coding Initiative Medically Unlikely Edits amount for the number of times this procedure can be billed on a date of services. An allowance has not been paid.

   The procedure code in question is a division-specific service reimbursed in accordance with 28 TAC §134.250 and is not subject to the National Correct Coding Initiative and Medically Unlikely Edits. 28 TAC §134.250 provides for reimbursement when incorporating one or more specialists' report(s) information into the final assignment of IR for non-musculoskeletal body areas. It is not included in the other services performed in this designated doctor examination.

   DWC finds that the insurance carrier did not support its denial of payment for procedure code 99456-W5-SP.

3. Because the insurance carrier failed to support its denial of payment for the services in question, DWC will review these services in accordance with applicable fee guidelines.

   The submitted documentation supports that Dr. Sklar performed an evaluation of maximum medical improvement (MMI) as ordered by the DWC. 28 TAC §134.250(3)(C) states that the maximum allowable reimbursement (MAR) for this examination is $350.00. DWC finds that Dr. Sklar is entitled to $350.00 for certification of MMI.

   Review of the submitted documentation finds that Dr. Sklar performed an evaluation and assigned impairment ratings for the (redacted and redacted) with range of motion testing.

   28 TAC §134.250(4)(C)(ii) defines the fees for the calculation of an impairment rating for musculoskeletal body areas. The MAR for the evaluation of the first musculoskeletal body

area performed with range of motion is $300.00. The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each.

The doctor also assigned an impairment rating for the (redacted). 28 TAC §134.250(4)(D) defines the fees for the calculation of an impairment rating for non-musculoskeletal body areas. The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.

DWC finds that Dr. Sklar is entitled to $600.00 for the assignment of impairment ratings for three body areas that included range of motion testing.

Dr. Sklar referred the injured employee to a specialist to provide a report to aid in determining the impairment rating for the (redacted). The use of this report is noted in the narrative. Per 28 TAC §134.250(4)(D)(iii), "reimbursement shall be $50 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination." DWC finds that Dr. Sklar is entitled to $50.00 for incorporating a specialist's report into the assignment of impairment rating for the non-musculoskeletal body area.

The total allowable reimbursement for the services in question is $1,000.00. Per explanation of benefits dated December 23, 2022, the insurance carrier paid $800.00. An additional $200.00 is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has established that additional reimbursement of $200.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Travelers Casualty & Surety Co. must remit to John Sklar, M.D. $200.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		May 17, 2024
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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option three or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1 (d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.