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

General Information

Requestor Name
Sandra Silmon, D.C.

Respondent Name
Arch Indemnity Insurance Company

MFDR Tracking Number
M4-24-1980-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
May 10, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 4, 2024	Designated Doctor Examination 99456 W5 WP	$500.00	$500.00
	Total	$500.00	$500.00

Requestor's Position

"We have not received payment on the attached bill. It was initially submitted on 01/17/2024. We called to check payment status and was informed of a change in TPA to CCMSI. On 02/23/2024, we mailed the bill to PO Box 802082, Dallas, TX 75380 and faxed the bill to 972-386-7918. On 03/05/24, we checked the website CCMSI.com, which does not show payment information. We then emailed bill to ciu@ccmsi.com. Today, we checked the website again for payment status, and it still does not show payment information."

Amount in Dispute: $500.00

Respondent's Position

The Austin carrier representative for Arch Indemnity Insurance Co. is Flahive Ogden & Latson. Flahive Ogden & Latson was notified of this medical fee dispute on May 14, 2024. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information. As of today, no response has been received from the carrier or its representative. Therefore, we will

base this decision on the information available at the time of review, as authorized under §133.307(d)(1).

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) §133.305 sets out the procedures for resolving medical disputes.
2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 TAC §133.240 sets out procedures for medical bill processing by insurance carriers.
4. 28 TAC §133.230 sets out the medical bill processing and auditing requirements for insurance carriers.
5. 28 TAC §134.250 sets the reimbursement guidelines for Maximum Medical Improvement Evaluations and Impairment Rating Examinations.

Denial Reasons

Neither party submitted explanation of benefits (EOBs) for consideration in this dispute.

Issues

1. Did the insurance carrier take final action on the medical bill in dispute as required by 28 TAC §133.240?
2. What is the description of the services in dispute?
3. What rules apply to reimbursement of the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. No explanation of benefits (EOBs) was submitted with the request for medical fee dispute resolution (MFDR). It is the duty of the workers' compensation insurance carrier or an agent acting on the insurance carrier's behalf to pay, reduce, or deny a complete medical bill within 45 days from receiving the bill.

   The procedures for medical bill processing by insurance carriers is set out in 28 TAC §133.240, which states in pertinent part,

   > "(a) An insurance carrier shall take final action after conducting bill review on a complete medical bill, or determine to audit the medical bill in accordance with §133.230 of this chapter (relating to Insurance Carrier Audit of a Medical Bill), not later than the 45th day after the date the insurance carrier received a complete medical bill. An insurance carrier's deadline to make or deny payment on a bill is not extended as a

result of a pending request for additional documentation…

(e)… The explanation of benefits shall be sent to: (1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill."

Furthermore, 28 TAC §133.230 which sets out auditing requirements for insurance carriers states,

"(a) An insurance carrier may perform an audit of a medical bill that has been submitted by a health care provider to the insurance carrier for reimbursement. The insurance carrier may not audit a medical bill upon which it has taken final action. (b) If an insurance carrier decides to conduct an audit of a medical bill, the insurance carrier shall: (1) provide notice to the health care provider no later than the 45th day after the date the insurance carrier received the complete medical bill."

A review of the submitted documents finds no evidence that the insurance carrier has either taken final action on the disputed medical bill in accordance with 28 TAC §133.240, nor is there evidence that the insurance carrier has notified the health care provider of its intent to conduct an audit in accordance with 28 TAC §133.230.

DWC finds that the insurance carrier has not taken final action on the disputed medical bill in accordance with 28 TAC §133.240. Therefore, this MFDR request will be adjudicated in accordance with 28 TAC §134.250, which sets out the fee guidelines for examinations to determine maximum medical improvement (MMI) and impairment rating (IR).

2. This dispute involves an examination by a designated doctor for the purpose of establishing: if maximum medical improvement (MMI) has been reached; what date MMI was reached if applicable; and to provide impairment ratings (IR) if MMI has been reached.

   On the disputed date of service, the requestor billed $500.00 for CPT code 99456-W5-WP. CPT code 99456 indicates the service of a maximum medical improvement (MMI) and/or impairment rating (IR) examination by a doctor other than the treating doctor. Modifier W5 indicates the examination was performed by a designated doctor. Modifier WP indicates that the same examining doctor performed the MMI examination and the IR testing of the musculoskeletal body area(s), thus reimbursement shall be 100 percent of the total maximum allowable reimbursement (MAR).

3. DWC finds that 28 TAC §134.250 applies to the reimbursement of the services in dispute.

   28 TAC §134.250, which sets out the fee guidelines for maximum medical improvement examinations and impairment ratings, states in pertinent part, "(3) 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. (4) The following applies for billing and reimbursement of an IR evaluation. (A) The health care provider shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the unit's column of the billing form… (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

   (i) Musculoskeletal body areas are defined as follows:

   (I) spine and pelvis;

(II) upper extremities and hands; and
(III) lower extremities (including feet).
(ii) The maximum allowable reimbursement (MAR) for musculoskeletal body areas shall be as follows:
(I) $150 for each body area if the diagnosis related estimates (DRE) method found in the AMA Guides fourth edition is used.
(II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area.
(iii) 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…"

4. The requestor, Sandra Silmon, D.C., is seeking reimbursement in the amount of $500.00 for a designated doctor examination rendered on January 4, 2024.

The submitted medical record supports that the requestor, a designated doctor, performed an evaluation of maximum medical improvement (MMI) as ordered by DWC. Per 28 TAC §134.250 (3)(C), the maximum allowable reimbursement (MAR) for this examination is $350.00.

A review of the submitted medical record additionally finds that the requestor performed an impairment rating (IR) evaluation of one musculoskeletal body area, with range of motion. The rule at 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 requestor assigned an impairment rating utilizing range of motion for one musculoskeletal body area. The total allowable reimbursement for the impairment rating of the one musculoskeletal body area with range of motion for this dispute is $300.00.

In accordance with 28 TAC §134.250, the reimbursements which apply to the disputed examination rendered on January 4, 2024, are:

- For an MMI examination, reimbursement is $350.00.
- For an IR of one musculoskeletal body area with range of motion, maximum allowable reimbursement is $300.00.
- DWC finds that the total maximum allowable reimbursement for the examination in question is $650.00.
- The requestor is seeking $500.00. This amount is recommended.

DWC finds that the requestor, Sandra Silmon, D.C., is entitled to reimbursement in the amount of $500.00 for the designated doctor examination rendered on January 4, 2024.

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 reimbursement in the amount of $500.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that the respondent, Arch Indemnity Insurance Co. must remit to the requestor, Sandra Silmon, D.C. $500.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 11, 2024 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, call CompConnection at 1-800-252-7031, option 3 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 3 o correo electronico CompConnection@tdi.texas.gov.