Texas Department of Insurance
Division of Workers' Compensation

FastFacts

For Insurance Carriers and Health Care Providers

Billing and Reimbursement for Designated Doctor Services

The Medical Fee Guideline, (28 Texas Administrative Code Section 134.202), addresses many services provided by Designated Doctors in 28 TAC section 134.202(e). The rules in this section of the Medical Fee Guideline provide the payment policies relating to coding, billing, and reporting for division-specific codes, services, and programs.

Billing and Reimbursement for Maximum Medical Improvement (MMI) / Impairment Rating (IR) Examinations

To calculate the Maximum Allowable Reimbursement (MAR) for a Maximum Medical Improvement (MMI) / Impairment Rating (IR) exam, begin with the MMI evaluation reimbursement and then add the reimbursement rate for the body area(s) evaluated for assignment of an IR. The following components are included in the reimbursement for the MMI / IR:
• Examination;
• Consultation with injured employee;
• Review of medical records and films;
• Reports, including the initial narrative report as well as any subsequent reports in response to the need for clarification, explanation, or reconsideration;
• Calculations, tables, figures, and worksheets; and
• Tests used to assign an IR, as outlined in the AMA's *Guides to the Evaluation of Permanent Impairment* (AMA *Guides*) [as stated in the Texas Labor Code and 28 TAC Section 130 rules].

To bill for an MMI / IR exam, enter the following information in block #24 of the CMS-1500 form for the designated doctor:
• MMI evaluation CPT®[1] code (99456);
• Appropriate modifiers;
• Units (musculoskeletal body areas); and/or
• CPT® code(s) for test(s) required for non-musculoskeletal areas rated.

[1] CPT® is a registered trademark of the American Medical Association

Information that Applies to Designated Doctors

If the Designated Doctor determines that MMI has not been reached, the MMI evaluation portion of the exam is billed using the CPT® code 99456 with the appropriate modifier. In this instance, use the following billing and reimbursement guidelines:
• The Designated Doctor bills using the CPT® code (99456);
• If the patient is not at MMI, then the provider uses the "NM" modifier; and
• MMI Evaluation reimbursement is $350, regardless of whether the injured worker is at MMI or not.

Billing and Reimbursement for Assignment of an Impairment Rating
To bill for an IR evaluation, enter the following information in block #24 of the CMS-1500:
• MMI evaluation CPT® code (99456);
• Appropriate modifiers; and
• Units (number of body areas rated).

The MAR for musculoskeletal body areas is as follows:
• $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA *Guides*, 4th edition, is used.

If a full physical evaluation with a range of motion test is performed, the MAR is as follows:
• $300 for the first musculoskeletal body area in which range of motion is measured, and
• $150 for each additional musculoskeletal body area.

Modifiers
If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the following guidelines apply:

• Examining doctor bills using the appropriate MMI CPT® code with the modifier "WP," and
• Reimbursement is 100 percent of the total MAR.

If the examining doctor performs the MMI examination and assigns the IR, but does not perform the testing of the musculoskeletal body area(s), the following guidelines apply:

• Examining doctor bills using the appropriate MMI CPT® code with the modifier "26," and
• Reimbursement is 80 percent of the total MAR.

If a health care provider other than the examining doctor performs the testing of the musculoskeletal body area(s), the following guidelines apply:

• HCP bills using the appropriate MMI CPT® code with modifier "TC," and
• Reimbursement is 20 percent of the total MAR.

Musculoskeletal Body Areas
The examining doctor may bill for a maximum of three musculoskeletal body areas, which are defined as follows:
• Spine and pelvis;
• Upper extremities and hands; and
• Lower extremities (including feet).

Non-musculoskeletal Body Areas
Non-musculoskeletal body areas are billed and reimbursed using the appropriate CPT® code(s) for the test(s) required for the assignment of IR. Non-musculoskeletal body areas are defined as:
• Body systems;
• Body structures (including skin); and
• Mental and behavioral disorders.

If the examining doctor refers testing for non-musculoskeletal body area(s) to a specialist and then incorporates the findings as part of the MMI/IR report, the following billing and reimbursement guidelines apply:
• The examining doctor (the referring doctor) bills using the appropriate MMI CPT® code with modifier "SP."
• The examining doctor enters one unit in the "units" column (box # 24g of the CMS-1500).
• Reimbursement is $50 for incorporating one or more specialist's report(s) information into the final assignment of IR.
• This $50 reimbursement is allowed only once per examination.
• The referral specialist bills and is reimbursed for the appropriate CPT® code(s) for the tests required for the assignment of an IR. Documentation is required.

When multiple IRs are required as a component of a designated doctor examination [see 28 TAC Section 130.6], the following guidelines apply:
• The designated doctor bills for the number of body areas rated;
• Reimbursement is $50 for each additional IR calculation; and
• Add the modifier "MI" to the MMI evaluation CPT® code.

Billing for Return to Work (RTW) and Evaluation of Medical Care (EMC) Exams
When conducting a RTW or EMC examination requested by the Division or an insurance carrier that is for a purpose other than certifying MMI and/or assigning an IR (e.g., a medical necessity issue), the following billing and reimbursement guidelines apply:
• The examining doctor bills and is reimbursed using the CPT® code 99456.
• The examining doctor uses the modifier "RE."
• Reimbursement is $350 and includes Division-required reports.
• Required testing is billed using the appropriate CPT® codes and is reimbursed in addition to the examination fee.

Information from Advisory 2004-06: Billing for Return to Work (RTW) and/or Evaluation of Medical Care (EMC) examinations

A carrier may request a doctor to perform an examination of the injured employee to determine the ability of the injured employee to return to work, to evaluate the medical care of the employee, or both. If the carrier asks, in a single request, for the doctor to both evaluate the medical care and to determine the ability of the injured employee to return to work, the doctor may bill and be reimbursed for each evaluation, both of which occurred in a single examination. In such cases, the doctor may use modifier "59" to indicate that the services performed to complete the carrier's request were distinct or independent, but appropriate under the circumstances.

Billing and Reimbursement for new Designated Doctor examinations such as extent of compensable injury, disability as a direct result of work-related injury (causality), and "similar issue" examinations

A designated doctor can be assigned to address the following topics:

(1) Assignment an impairment rating (IR) caused by a compensable injury in accordance with the *Guides to the Evaluation of Permanent Impairment*, 4th Edition, published by the American Medical Association;
(2) Determining attainment of clinical maximum medical improvement (MMI);
(3) Determining the extent of the employee's compensable injury;
(4) Determining whether the injured employee's disability is a direct result of the work-related injury;
(5) Determining the ability of the employee to return to work; or
(6) Issues similar to those described by (1)-(5).

A designated doctor who addresses one or more of the new issues should bill using the CPT® code (99456) with an "RE" modifier [see 28 TAC Section 134.202(e)(7)].

A doctor may be requested to perform any combination of one or more of the six types of examinations. If the carrier asks, in a single request, for the doctor to both evaluate the medical care and to determine the ability of the injured employee to return to work, the doctor may bill and be reimbursed $350 for each evaluation, any of which occurred in a single examination. In such cases, the doctor may use modifier "59" to indicate that the services performed to complete the carrier's request were distinct or independent, but appropriate under the circumstances. The reimbursement includes Division required reports.

Example of a Designated Doctor billing for new Designated Doctor Examination

In this example, the Division made a single request to the Designated Doctor to examine the injured employee to determine the ability of the injured employee to return to work and to determine if the injured employee's disability was a direct result of the work-related injury. In this example, the Designated Doctor conducted two distinct examinations on the same day and would bill as follows:

1. The return to work examination would be billed as 99456-RE, 1 unit, and $350.
2. The causality examination would be billed as 99456-RE-59, 1 unit, and $350.

The National Correct Coding Initiative bundling procedural guidance and preauthorization rule (28 TAC Section 134.600) do not apply to medical services associated with Designated Doctor examinations.