



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

Bruce Weiner, M.D.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-11-1588

Carrier's Austin Representative

Box Number 54

MFDR Date Received

January 20, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... he was certified and is in same office of Dr.Randall and he would be acting as treating doctor selected by treating Dr.Randall."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor used code 99455-V3-WP to bill the exam. Rule 134.204 at (j)(3)(A) states, '...An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.' The requestor is not the treating doctor."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 8, 2010	Referral Doctor Examination to Determine Maximum Medical Improvement & Impairment Rating	\$350.00	\$0.00

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.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the fee guidelines for Division-specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.

- 732 – Accurate coding is essential for reimbursement. CPT and/or modifier billed incorrectly. Services are not reimbursable as billed.
- 891 – No additional payment after reconsideration.
- CAC-18 – Duplicate claim/service.

Issues

Are the insurance carrier’s reasons for denial or reduction of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code 732 – “ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. CPT AND/OR MODIFER BILLED INCORRECTLY. SERVICES ARE NOT REIMBURSABLE AS BILLED.” 28 Texas Administrative Code §134.204(j)(3) states,

The following applies for billing and reimbursement of an MMI evaluation.

- (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier.
 - (i) Reimbursement shall be the applicable established patient office visit level associated with the examination.
 - (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit.
- (B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has:
 - (i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this subsection; or,
 - (ii) not previously treated the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(C) of this subsection.
- (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.

Review of the submitted information finds that the requestor performed the examination in question on the referral of the treating doctor, with billing subject to 28 Texas Administrative Code §134.204(j)(3)(B). Submitted documentation does not support that the requestor has previously been treating the injured employee. Therefore, the referral doctor was required to bill the examination in accordance with paragraph 28 Texas Administrative Code §134.204(j)(3)(C). The insurance carrier’s denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional 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

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	December 4, 2015 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MFDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of this *Medical Fee Dispute Resolution Findings and Decision***, together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.