Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARAR A YUSUF MD
10109 MCKALLA PLACE STE E
AUSTIN TX 78758

Respondent Name
TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative
Box Number 54

MFDR Tracking Number
M4-13-1015-01

MFDR Date Received
December 27, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was billed in error; please refer to the corrected CMS-1500 attached. This claim was for a Division ordered Designated Doctor Exam. We billed a total of $1,400.00 for this claim but were paid only $750.00; when in fact, $1,100 should have been billed. The explanation given on the EOB justifying the denial states: THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING. The reduction of parts of the claim is in violation of the rules of the Texas Department of Insurance Division of Workers' Compensation as this services was ordered on the DWC-32."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 5/26/12 … The requestor contacted Texas Mutual the date of this response to point out that it had in fact submitted the correct coding for the issue cited above. Nevertheless, Texas Mutual continued to deny payment. The requestor submitted the request on 9/24/12 with coding of 99456-W5-NM. Rule 133.250(d)(1) states in part "the request for reconsideration shall … reference the original bill and include the same billing codes, date(s) of service, and dollar amount as the original bill…" The total billed amount on the original bill was $1400.00; the reconsideration bill, $1100.00. The original bill listed code 99456-W5-WP (2); the reconsideration bill lists 99456-W5-NM. Although the requestor believes it submitted a request for reconsideration, the requirements of 133.250 have not been met, which means, as Texas Mutual understands it, that the request for reconsideration is a new bill, and what makes it a new bill is a different code 99456-W5-NM and a different dollar amount. Texas Mutual denied payment for this billing for code 99456-W5-NM as untimely. … NO additional payment is due."

Response Submitted by:

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 26, 2012	CPT Code 99456-W5-NM	$350.00	$ 0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline procedures for professional medical services.
3. 28 Texas Administrative Code §133.250 sets out the medical bill processing/audit by insurance carrier for reconsideration for payment of medical bills.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 29, 2012
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CAC-4 – THE PROCEDURE CODE IS INCOSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING
   - 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. MODIFIER BILLED INCORRECTLY OR MISSING. SERVICES ARE NTO REIMBURSEABLE AS BILLED
   - 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE

   Explanation of benefits dated November 05, 2012
   - CAC-18 – DUPLICATE CLAIM/SERVICE
   - CAC-29 – THE TIME LIMIT FOR FILING HAS EXPIRED
   - 224 – DUPLICATE CHARGE
   - 731 – PER 133.20 PROVIDER SHALL NOT SUBMIT A MEDICAL BILL LATER THAN THE 95TH DAY AFTER THE DATE THE SERVICE, FOR SERVICES ON OR AFTER 9/1/05

Issues

1. Did the requestor submit the request for reconsideration in accordance with §133.250
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §133.250 states in part (d) The request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill; (2) include a copy of the original explanation of benefits, if received, or documentation that a request for an explanation of benefits was submitted to the insurance carrier.

   Review of the medical bills provided notes that the request for reconsideration bill differs from the original medical bill as the billing codes and total charge were changed. Therefore, CPT Code 99456-W5-WP is not supported and does not meet the requirement of 28 Texas Labor Code §133.250.
2. The respondent issued payment in the amount of $0.00. Based upon the documentation submitted, no additional reimbursement is 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	Medical Fee Dispute Resolution Officer	3/7/14 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

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