



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

EDWIN J TAEGEL MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-13-2455-01

Carrier's Austin Representative

Box Number # 54

MFDR Date Received

May 28, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was billed in error; a corrected CMS-1500 is attached. This claim was for a Division ordered Post Designated Doctor Required Medical Exam. We billed a total of \$1,000.00 for this claim but were paid nothing. The explanation given on the EOB justifying the denial states: *WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT; THE PROCEDURE CODE IS INCOSINSTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.* The reduction of parts of this claim is in violation of the rules of the Texas Department of Insurance Division of Worker's Compensation as this service was ordered on the DWC-22."

Amount in Dispute: \$500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "... The requestor submitted a request for reconsideration (RFR) that Texas Mutual received 3/27/13. (Attachment) Rule 133.250(d)(1) requires the same billing codes and dollar amounts as the original bill. The RFR bill had a different dollar amount and the same billing codes (including the incorrect modifier) but with the additional of a new modifier. The requestor may argue that a modifier is not a billing code; however, if the modifier has the potential to materially affect reimbursement it must have the status of a billing code. As a consequence the RFR bill is really a new bill that is untimely."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 26, 2012	CPT Code 99456-RE-WP	\$500.00	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.250 sets out the reconsideration for payment of medical bills.
- The services in dispute were reduced/denied by the respondent with the following reason codes:

- 732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed
- 892 – Denied in accordance with DWC Rules and/or medical fee guideline including current cpt code description/instructions

Issues

1. Is the requestor’s request for reconsideration submitted to the carrier in accordance with 28 Texas Administrative Code §133.250?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Labor Code §133.250 (d)(1) states “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;”
Review of submitted bills provided by the requestor for date of service November 26, 2012 finds the request for reconsideration bill differ from the original bill. The original bill has documented one unit for CPT Code 99456 RE in the amount of \$350.00 and one unit for CPT Code 99456 RE in the amount of \$150.00, request for reconsideration bill is documented as followed one unit for CPT Code 99456-RE-WP in the amount of \$350.00 and one unit for CPT Code 99456-RE-WP in the amount of \$150.00.
2. The respondent issued payment in the amount of \$0.00 for CPT Code 99456-RE-WP. 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	4/11/14 Date
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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.