



# 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**

DELBERT L MCCAIG

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-13-2718-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

June 24, 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 Designated Doctor Exam. We billed a total of \$1,000.00 for this claim but were paid only \$500.00 the explanation given on the EOB justifying the denial states: *CLAMI/SERVICE LACKS INFORMATION WHICH IS NEED FOR ADJUDICATION/ THE PROCEDURE CODE IS INCONSISTENT WITH 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 Workers' Compensation as this service 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 1/26/13. The requestor as designated doctor was asked to determine MMI, the rate if impairment, and the extent of injury. The requestor determined that MMI had not been reached and determined the extent of injury.

The requestor billed \$350.00 for the MMI exam with code 99456-W5-WP. Rule 134.204(j)(2)(A) states "... if the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added." However, the requestor failed to do this and coded it incorrectly. As a result Texas Mutual declined to issue payment."

**Response Submitted by:** Texas Mutual Insurance Company

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 26, 2013	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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.204 sets out the procedures for fee guideline for workers' compensation specific services.
3. 28 Texas Administrative Code §133.250 sets out the procedures for reconsideration for payment of medical bills.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
  - 732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed
  - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that his claim was processed properly
  - CAC-4 – The procedure code is inconsistent with the modifier used for a required modifier is missing
  - 732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed
  - 724 – No additional payment after a reconsideration of services. For information call 1 800-937-6824

### Issues

1. Did the requestor bill the respondent for the disputed services appropriately?
2. Is the requestor entitled to reimbursement?

### Findings

1. 28 Texas Labor Code §134.204 states (j) Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows:
  - (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include
  - (2) An HCP shall only bill and be reimbursed for an MMI/IR examination if the doctor performing the evaluation (i.e., the examining doctor) is an authorized doctor in accordance with the Act and Division rules in Chapter 130 of this title
  - (A) If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added

Review of the requestor's submitted documentation finds DWC-69 which in Part III box (b) is checked off which states: "No, I certify that the employee has **NOT** reached MMI but is expected to reach MMI on or about 03/26/2013. The reason the employee has not reached MMI is documented in **the attached narrative**. In the Examining Doctor's Report the performing doctor addressed MMI and has also stated "The expected date of maximum medical improvement is 03/26/13." The examining doctor initially billed with incorrect modifiers, CPT Code 99456-W5-WP with one unit in the amount of \$350.00 in the original medical bill submission then corrected the modifiers in its request for reconsideration submission with CPT Code 99456-W5-NM with one unit for \$350.00.

However, 28 Texas Labor Code §133.250 states (a) If the health care provider is dissatisfied with the insurance carrier's final action on a medical bill, the health care provider may request that the insurance carrier reconsider its action. If the health care provider is requesting reconsideration of a bill denied based on an adverse determination, the request for reconsideration constitutes an appeal for the purposes of §19.2011 of this title (relating to Written Procedures for Appeal of Adverse Determinations) and may be submitted orally or in writing

- (b) The health care provider shall submit the request for reconsideration no later than 10 months from the date of service
- (c) A health care provider shall not submit a request for reconsideration until
  - (1) the insurance carrier has taken final action on a medical bill; or
  - (2) the health care provider has not received an explanation of benefits within 50 days from submitting the medical bill to the insurance carrier
- (d) A written 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 submitted finds the original medical bill and the request for reconsideration bill submission are different and not in accordance with 28 Texas Labor Code §133.250. Original bill has date of service January 26, 2013 with CPT Code 99456-W5-WP with one unit for the amount of \$350.00 then request for reconsideration bill has CPT Code 99456-W5-NM with one unit for the amount of \$350.00 Therefore, CPT Code 99456-W5-NM is not supported and no additional reimbursement is due.

- 2. The respondent issued payment in the amount of \$0.00 for CPT Code 99456-W5-NM. 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

6/13/14  
\_\_\_\_\_  
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.**