



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

RAMESH D SHAH MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-13-2725-01

Carrier's Austin Representative

Box Number: 54

MFDR Date Received

JUNE 24, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated in the request for reconsideration letter dated April 30, 2013:

"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 \$1,450.00 for this claim and were paid only \$1,300.00. The explanation given on the EOB justifying the denial states: THE VALUE OF THIS PROCEDURE IS INCLUDED IN THE VALUE OF ANOTHER PROCEDURE PERFORMED ON THIS DATE; however, this is incorrect. 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: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 2/11/13. The requestor as designated doctor performed MMI/IR exams of the claimant. The requestor performed range of motion to the lower extremities and billed \$150.00 for this with CPT code 95861-W5,WP. Rule 134.204(j)(4)(A)(C)(ii)(II)(b) indicates the requestor should have billed 99456-W5, WP for this lower extremity range of motion but did not. For this reason Texas Mutual declined to issue payment."

Response Submitted by: TEXAS MUTUAL INSURANCE CO

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 11, 2013	CPT Code 99456-W5-WP	\$150.00	\$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. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

- W1 – Workers Compensation State Fee Schedule Adjustment.
- 217 – The value of this procedure is included in the value of another procedure performed on this date.
- 714 – Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly. Corrections must be submitted w/ 95 days from DOS.
- 18 – Duplicate claim/service.
- 224 – Duplicate charge.

Issues

1. Did the requestor submit a bill for the service in dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. According to the table of disputed services submitted by the requestor, the only service in dispute is CPT Code 99456-W5-WP in the amount of \$150.00. The request for reconsideration letter dated April 30, 2013 states, “The enclosed claim was billed in error; a corrected CMS-1500 is attached.” In accordance with 28 Texas Administrative Code §133.307(J), a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions). Review of the submitted medical bills finds that medical bills containing CPT Code 99456-W5-WP in the amount of \$150.00 were not submitted. Therefore, the requestor has not met the requirements of the rule.
2. Because the requestor has not submitted medical bills for the service in dispute reimbursement is not 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	June 13, 2014 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.