



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

KYLE POWER, PT

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-13-3252-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

AUGUST 6, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary.

Amount in Dispute: \$100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed Texas Mutual code 99456-GP-TC for the date above. (Attachment 1) Review of Texas Mutual's claim file shows the requestor has treated the claimant. For this reason the requestor should have billed code 99455 with the appropriate modifier. Because 99456 is not the correct code Texas Mutual declined to issue payment. The requestor submitted a bill that Texas Mutual received 7/2/13. Although styled a 'Request for Reconsideration,' it is in fact a new bill given the change of modifier from GP-TC to TC. (Attachment 2) Texas Mutual declined to pay this bill due untimely filing and incorrect coding. No payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 20, 2013	CPT Code 99456-TC Designated Doctor Evaluation	\$100.00	\$70.00

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 §134.204, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-W1-Workers compensation state fee schedule adjustment.
 - CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
 - 714-Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly. Corrections must be submitted w/ 95 days from DOS.

- 724-No additional payment after a reconsideration of services.
- 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 this claim was processed properly.

Issues

Did the Designated Doctor bill for the MMI/IR evaluation in accordance with medical fee guideline? Is the requestor entitled to reimbursement?

Findings

On the disputed date of service the requestor billed CPT code 99456-TC.

- 28 Texas Administrative Code §134.204(j)(3) states “The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.”

The requestor billed CPT code 99456 because the examination was performed by a designated doctor.

- 28 Texas Administrative Code §134.204(j)(4)(C)(v) states “If a HCP, other than the examining doctor, performs the range of motion, sensory, or strength testing of the musculoskeletal body area(s), then the HCP shall bill using the appropriate MMI CPT code with modifier "TC." In accordance with §130.1 of this title, the HCP must be certified. Reimbursement shall be 20 percent of the total MAR”

The requestor appended modifier “TC” to code 99456 in accordance with 28 Texas Administrative Code §134.204(j)(4)(C)(v).

The MAR for a designated doctor examination is \$350.00; therefore, 20% of \$350.00 = \$70.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$70.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$70.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	Date
		<u>11/19/2014</u>

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.