



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

UNITED MEDICAL EVALUATORS
DR. RODNEY L. CALDWELL

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-0925-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

NOVEMBER 20, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "it appears that we did not receive reimbursement for incorporation of a Specialist Report. As outlined in DWC Rule 134.204(j)."

Amount in Dispute: \$50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor seeks '\$50.00 for incorporating one or more specialist's report(s) information into the final assignment of IR...' The report is a Functional Capacity Evaluation. Texas Mutual has reviewed the IR portion of the requestor's report and finds no reference to the report or any part of it incorporated into the IR exam or discussion by the requestor in his assignment of the IR. Absent such no payment is due."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 18, 2013	CPT Code 99456-SP	\$50.00	\$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 §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-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 724-No additional payment after a reconsideration of services.

- 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issues

Is the requestor entitled to reimbursement?

Findings

On the disputed date of service the requestor billed CPT codes 99456-SP.

28 Texas Administrative Code §134.204(j)(4)(D)(iii)(I) states “ The examining doctor (e.g., the referring doctor) shall bill using the appropriate MMI CPT code with modifier "SP" and indicate one unit in the units column of the billing form. Reimbursement shall be \$50 for incorporating one or more specialists' report(s) information into the final assignment of IR. This reimbursement shall be allowed only once per examination.”

A review of the Designated Doctor report finds that the requestor does not document what information from the specialists' report was used in the final assignment of IR to support billing. As a result, no 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

Date

10/15/2014

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.