



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

THOMAS CASTOLDI DO

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-2903-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

May 19, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please accept the attached claim for RECONSIDERATION/APPEAL for payment at this time for the following rationale.

NON PAYMENT FOLLOWING CARRIER'S RECEIPT OF INTIAL SUBMISSION."

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 7/27/13. The requestor provided DESIGNATED DOCTOR services on the date above and then billed Texas Mutual code 99456-W5,WP. The requestor performed range of motion to the upper and lower extremities and used the DRE method for the spine. Texas Mutual paid \$350.00 for the MMI exam, \$150.00 for the DRE, \$150.00 for the upper extremity exam, and nothing for the lower extremity range of motion based on the number of units billed."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 27, 2013	CPT Code 99456-W5-WP	\$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.
- 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-W3 – In accordance with TDI-DWC Rule 134.801, the bill has been identified as a request for reconsideration or appeal.
 - CAC-193 – Original payment decision is being maintained upon review, it was determined that this

claim was processed properly

- 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
- 724 – No additional payment after a reconsideration of services. For information call 1-800-937-6824
- CAC-W1 - Workers Compensation State Fee schedule adjustment
- 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline

Issues

1. Were the disputed services billed in accordance with 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (j)(4)(A) states “The HCP shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the units column of the billing form.” Review of submitted documentation finds medical bills provided by the requestor indicates disputed service billed with CPT Code 99456-W5-WP in the amount of \$950.00 with one unit billed. In order for the requestor to be billed for the number of body area rated per documentation submitted the requestor was required to bill the disputed services in accordance with 28 Texas Administrative Code §134.204 (j)(4)(A). Therefore, CPT Code 99456-W5-WP is not supported. No additional reimbursement is recommended.
2. 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

11/26/14

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.