



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

STEPHEN J BELL MD

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-14-3228-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

June 24, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Attached is a copy of the EOB's which states "code is inconsistent with modifier" and we have appealed this bill with corrected code and we are still getting denied."

**Amount in Dispute:** \$350.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Texas Mutual Insurance Company received a TWCC-60 from the above-mentioned requester. Pursuant to Commission Rule 133.307(d) Texas Mutual files the attached, completed response, and related items.

The following is the carrier's statement with respect to this dispute of 8/2/13. Treating doctor asked the requestor to determine MMI/IR of the claimant. The requestor determined the claimant was not at MMI. Because the requestor has consistently miscoded the billing. Texas Mutual has been unable to authorize payment."

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

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 02, 2013	CPT Code 99456-WP-V3	\$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 on or after March 1, 2008.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - CAC-W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS 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

- CAC-4 – THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING
- 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 1-800-37-6824
- 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. MODIFIER BILLED INCORRECTLY OR MISSING. SERVICES ARE NOT REIMBURSABLE AS BILLED
- CAC-18 – EXACT DUPLICATE CLAIM/SERVICE
- 736 – DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY TEXAS STAR NETWORK. CALL 1-800-381-8067- FOR RECONSIDERATION DISCUSSION
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**Issues**

1. Did the requestor bill the respondent appropriately for the disputed services 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)(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.”  
Review of the submitted documentation finds the requestor was required to evaluate the injured employee for maximum medical improvement and impairment rating. Documentation provided supports the requestor evaluated the injured employee for maximum medical improvement and impairment rating, however; the injured employee did not reach maximum medical improvement. The requestor billed the procedure with CPT Code 99456-WP-V3 with one unit in the amount of \$350.00.  
Therefore, the requestor did not bill the service in dispute in accordance with 28 Texas Administrative Code §134.204(j)(2)(A).
2. The respondent issued payment in the amount of \$0.00. 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

12/10/14  
\_\_\_\_\_  
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.**