TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Stacy C. Croft, D.C.

**Respondent Name**
Texas Mutual Insurance Company

**MFDR Tracking Number**
M4-15-3619-01

**Carrier's Austin Representative**
Box Number 54

**MFDR Date Received**
July 3, 2015

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "This was a bill for an Impairment Rating examination as referred by the claimant's treating doctor. The payment issued to us does not meet the recommended allowance as set by the Texas Medical Fee Guidelines."

**Amount in Dispute:** $650.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The requestor conducted MMI/IR exams on the date above and then billed Texas Mutual code 99456-RE/WP at $350.00 and $300.00 respectively. Because of the inconsistency between the billing code and the documentation Texas Mutual declined to issue payment."

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

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 31, 2015 | Referral Doctor Examination to determine MMI/IR | $650.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.

- 732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed.
- 892 – Denied in accordance with DWC rules and/or medical fee guidelines including current CPT code descriptions/instructions.
- 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.

**Issues**

Are the insurance carrier's reasons for denial or reduction of payment supported?

**Findings**

The insurance carrier denied disputed services with claim adjustment reason code "CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing," and "732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed." 28 Texas Administrative Code §134.204 (k) states,

> The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.'

Review of the submitted information finds that the examination in dispute was not requested by the Division or the insurance carrier. Further, the narrative and requestor's position statement indicate that the examination in dispute is for an examination to determine if the injured employee had reached maximum medical improvement, and if so, determine the impairment rating. These examinations are addressed in28 Texas Administrative Code §134.204 (j). The insurance carrier's denial reason is supported. Additional reimbursement cannot be 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**

| | Laurie Garnes | July 29, 2015 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | 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, 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 MFDR 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**.