



**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**

ROBERT J. COOLBAUGH, DC

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-15-3956-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

AUGUST 6, 2015

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "This code of 77456 is correct since we only performed an FCE which was needed to determine patients impairment rating/MMI."

**Amount in Dispute:** \$650.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "The requestor performed an FCE on the patient on January 15, 2015. The CPT Code used (99456) for the date of service in question (02/18/2015) is not accurate as the requestor had treated the patient 34 days prior, on January 15, 2015."

**Response Submitted by:** Texas Mutual Insurance Co.

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2015	CPT Code 99456-WP Designated Doctor Evaluation	\$650.00	\$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-P12-Workers' compensation jurisdictional fee schedule adjustment.
  - 714-Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly. Corrections must be submitted w/ 95 days from DOS.
  - CAC-W3, 350-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.
  - 891-No additional payment after reconsideration.

**Issues**

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

**Findings**

According to the explanation of benefits, the respondent denied reimbursement for code 99456-WP based upon reason code "714." The respondent further contends that "The requestor performed an FCE on the patient on January 15, 2015. The CPT Code used (99456) for the date of service in question (02/18/2015) is not accurate as the requestor had treated the patient 34 days prior, on January 15, 2015."

28 Texas Administrative Code §134.204(j)(3)(B)(i) states "Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: (3) The following applies for billing and reimbursement of an MMI evaluation (B) If the treating doctor refers the injured employee to another doctor for the examination and certification of MMI (and IR); and, the referral examining doctor has: (i) previously been treating the injured employee, then the referral doctor shall bill the MMI evaluation in accordance with paragraph (3)(A) of this subsection."

A review of the submitted documentation finds that the requestor performed a Functional Capacity Evaluation, (FCE), on the claimant on January 15, 2015; therefore, the respondent's denial of reimbursement based upon reason code "714" is supported per 28 Texas Administrative Code §134.204(j)(3)(B)(i). As a result, reimbursement is not 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**

		09/11/2015
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, 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.**