



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

Thomas Castoldi, D.O.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-16-0048-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

September 8, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... this request was in response to a \$350.00 reduction of the \$1115.00 for the DDE performed on 01/28/2015."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester billed \$350.00 for code 99456-W5/NM but did not fully complete the DWC69; Box 10, requiring the certifying doctor's license number and jurisdiction, is blank. Absent completion, 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 |
|------------------|-------------------------------|-------------------|------------|
| January 8, 2015 | Designated Doctor Examination | \$350.00 | \$350.00 |

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

- 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 guidelines for Division-specific services.
- Texas Labor Code §408.0041 sets out the procedures for designated doctor examinations.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
 - 892 – Denied in accordance with DWC rules and/or medical fee guideline 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

1. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. While charges for a work status form and examinations to determine if disability is a direct result of the injury and the injured employee's ability to return to work were included on the Medical Fee Dispute Resolution Request (DWC060), the requestor is seeking \$0.00 for these charges. Therefore these charges will not be considered for this dispute.

Per 28 Texas Administrative Code §134.204 (j)(2)(A), "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."

Further, 28 Texas Administrative Code §134.204 (j)(3) states, "The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." The submitted documentation indicates that the requestor performed an evaluation of Maximum Medical Improvement and found that the injured employee was not at maximum medical improvement. Therefore, the correct MAR for this examination is \$350.00.

2. Texas Labor Code §408.0041 (h) states, "The insurance carrier shall pay for: (1) an examination required under Subsection (a), (f), or (f-2), **unless otherwise prohibited** [emphasis added] by this subtitle or by an order or rule of the commissioner." The submitted documentation does not support that payment is prohibited for the disputed services. The total MAR is \$350.00. The insurance carrier paid \$0.00. An additional reimbursement of \$350.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$350.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$350.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

September 30, 2015
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.