



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

Joan Krajca-Radcl, M.D.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-16-0159-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

September 18, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "... the payment issued to us does not meet the recommended allowance as set by the Texas Medical Fee Guidelines for the procedures billed."

Amount in Dispute: \$100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed code 99456 for multiple impairments, 2 units on both the initial bill and the request for reconsideration bill ... The two bills above are missing modifier 'MI.' No payment is due."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 19, 2015	Designated Doctor Examination	\$100.00	\$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

- 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.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 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.

- 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 of payment supported?

Findings

Charges for an examination to determine maximum medical improvement, impairment rating, extent of injury, if disability was due to the compensable injury, and the ability of the injured employee to return to work were included on the Medical Fee Dispute Resolution Request (DWC060). However, the requestor is seeking \$0.00 for these charges. Therefore these charges will not be considered. Review of this dispute will only include charges requestor is seeking for CPT code 99456-MI, as indicated on the DWC060.

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 REIMRUSEMENT. MODIFIER BILLED INCORRECTLY OR MISSING. SERVICES ARE NOT REIMBURSABLE AS BILLED.”

28 Texas Administrative Code §134.204 (j)(4)(B) states,

When multiple IRs are required as a component of a designated doctor examination under §130.6 of this title (relating to Designated Doctor Examinations for Maximum Medical Improvement and/or Impairment Ratings), the designated doctor shall bill for the number of body areas rated and be reimbursed \$50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code.

Review of the submitted information does not support that a bill for CPT code 99456-MI was submitted to the insurance carrier prior to the request for medical fee dispute. 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

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

October 7, 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.