



# 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**

Jack P. Mitchell, D.C.

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-16-0735-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

November 16, 2015

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "According to DWC rule the examining doctor should be reimbursed on a tier schedule for the non-MMI/IR evaluations. \$500 for Return to Work, Procedural Code 99456 applies to other doctors who have not previously treated the injured worker. Modifier RE shall be added to CPT code 99456 when a RTW or EMC examination is performed"

**Amount in Dispute:** \$500.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "JACK P MITCHELL DC's DWC60 packet contains evidence of only one bill submission and no evidence a request for reconsideration was submitted to Texas Mutual. For its part Texas Mutual only has the one bill in its claims processing system and no record of receiving an appeal..."

No payment is due."

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

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 18, 2015	Referral Doctor Examination to Determine the Work Status of the Injured Employee	\$500.00	\$500.00

### 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-18 – Exact duplicate claim/service.

- 224 – Duplicate charge.

### Issues

1. Are the insurance carrier’s reasons for denial of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed service?
3. Is the requestor entitled to additional reimbursement?

### Findings

1. The insurance carrier denied disputed services with claim adjustment reason codes CAC-18 – “EXACT DUPLICATE CLAIM/SERVICE,” and 224 – “DUPLICATE CHARGE.” Review of the submitted information finds that a previous review of these services is not supported.

In their position statement, the insurance carrier states that the requestor provided “evidence of only one bill submission and no evidence a request for reconsideration was submitted to Texas Mutual.” The explanations of benefits submitted include review dates of September 18, 2015 and September 21, 2015. Submitted information included documentation supporting a request for reconsideration sent to Texas Mutual by fax on October 12, 2015.

The division concludes that the insurance carrier’s denial reasons are not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The requestor is seeking reimbursement for CPT code 99456-RE, which is subject to the fee guidelines in 28 Texas Administrative Code §134.204(k), which state, in relevant part,

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." In either instance of whether MMI/IR is performed or not, the reimbursement shall be \$500 in accordance with subsection (i) of this section and shall include Division-required reports.

Therefore, the correct MAR for the disputed service is \$500.00.

3. The MAR for the disputed service is \$500.00. The insurance carrier paid \$0.00. A reimbursement of \$500.00 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 \$500.00.

### **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 \$500.00 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

December 22, 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.**