



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Terry J, Beal, M.D.

Respondent Name

Service Lloyds Insurance Company

MFDR Tracking Number

M4-16-1444-01

Carrier's Austin Representative

Box Number 1

MFDR Date Received

January 29, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "There has been no explanation from Service Lloyds Insurance as to why this claim was denied."

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "... the Requestor submitted their bill with code 99456, but without any modifier as is required per rule 134.204. As such, the Requestor's bill was denied with Claims Adjustment Reason Code (CARC) 4 which, indicates: *Required Modifier Missing or Inconsistent w/ procedure*. This EOB was mailed to the provider.

... It should be noted that the Requestor submitted a request for reconsideration 7 days **before** the Division received this MFDR...

... The Requestor's request for reconsideration still does not contain the correct modifier... The Requestor has used modifiers that are restricted to use by **designated doctors** as per rule 134.204(I)(1)(A) and (B)..."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 15, 2015	Referral Doctor Examination to Determine Maximum Medical Improvement & Impairment Rating	\$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

- 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 fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 4 – Required modifier missing or inconsistent with procedure.

Issues

Is the insurance carrier’s reason for denial of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code 4 – “Required Modifier Missing or Inconsistent w/proced.” The requestor is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating. Review of the submitted documentation finds the billed procedure code is 99456-W5.

28 Texas Administrative Code §134.204(i) states,

The following shall apply to Designated Doctor Examinations.

- (1) Designated Doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041 and 408.151 and Division rules, and shall be billed and reimbursed as follows:
 - (A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier **"W5" is the first modifier to be applied when performed by a designated doctor** [emphasis added];
 - (B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with subsection (j) of this section, and the use of the additional modifier **"W5" is the first modifier to be applied when performed by a designated doctor** [emphasis added];

Review of the submitted information does not support that the requestor was a designated doctor for this examination. 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	February 18, 2016
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.