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
Miguel A. Arredondo, D.C.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-16-1936-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 8, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This service was referred by the examinee's treating doctor for purpose of Maximum Medical Improvement and Impairment Rating and billed accordingly."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "According to the requestor's 10/20/15 narrative report the requester was requested by the treating doctor to address MMI and IR. However, the requestor on the DWC69 form itself indicated instead he was the designated doctor. Because of the inconsistency Texas Mutual denied payment."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 20, 2015	Referral Doctor Examination to Determine Maximum Medical Improvement & Impairment Rating	$350.00	$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

1. 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:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 748 – Type of examination was not requested (refer to DWC 22 or DWC 32).
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT 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

Are the insurance carrier's reasons for denial of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code 225 – "THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BIENG BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION." Review of the submitted information finds that the requestor indicated that he was acting as a "Designated Doctor selected by the DWC," as noted on the Report of Medical Evaluation. Review of the submitting billing documentation finds that the requestor did not use the billing code modifiers associated with billing for a designated doctor examination in accordance with 28 Texas Administrative Code §134.204. For this reason, 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 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	May 25, 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.