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
JAIME MILES, DC

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-17-2138-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
MARCH 15, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $45.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The DWC60 lists CPT code 97750-FC with disputed charges in the amount of $45.00, however the bills submitted as evidence are for a MMI/IR evaluation billing CPT codes 99456-W5NM, 99456W8RE and 99080-73. The Office researched the requestor's billing as submitted as evidence and found that payment in the amount of $850.00 had been previously made. However, a denial had been issued for CPT code 99080-73. The Office will maintain our denial for CPT 99080-73 as pursuant to Rule 134.204 (k) this is a Division required report and the reimbursement for 99456W8RE includes Division required reports."

Response Submitted by: SORM

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 25, 2016	CPT Code 99080-73 Work Status Report	$45.00	$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, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - P12-Workers' compensation jurisdictional fee schedule adjustment.
   - 4151-An allowance was not paid for the work status report. Reimbursement to RME doctors and designated doctors for the report is included in the reimbursement for the examination.

Issues

1. Did the requestor submit the dispute in accordance with 28 Texas Administrative Code §133.307? What is the disputed service?
2. Is the allowance for CPT code 99080-73 included in the allowance of another service rendered on the disputed date?

Findings

1. A review of the submitted Table of Disputed Services indicate that the service in dispute is code 97750-FC for $45.00.

   28 Texas Administrative Code §133.307(c)(2)(F) requires the requestor to list "the treatment or service code(s) in dispute." The requestor listed code 97750-FC.

   28 Texas Administrative Code §133.307(c)(2)(J) requires the requestor to submit "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions)." The requestor failed to submit any medical bill for code 97750-FC. The submitted medical bill indicates the requestor billed codes 99456-W5-NM, 99456-W8-RE, and 99080-73.

   28 Texas Administrative Code §133.307(c)(2)(K) requires the requestor to submit "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB." The requestor failed to submit any explanation of benefits for code 97750-FC. The submitted explanation of benefits indicates the requestor billed codes 99456-W5-NM, 99456-W8-RE, and 99080-73.

   The Division finds that the requestor did not complete the Table of Disputed Services in accordance with 28 Texas Administrative Code §133.307(c)(2)(F). The Division concludes that based upon the amount billed the service in dispute is code 99080-73 for $45.00.

2. The respondent denied reimbursement for code 99080-73 based upon reason code "4151-An allowance was not paid for the work status report. Reimbursement to RME doctors and designated doctors for the report is included in the reimbursement for the examination."

   - 28 Texas Administrative Code §134.204 (l) states "The following shall apply to Work Status Reports. When billing for a Work Status Report that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section, refer to §129.5 of this title (relating to Work Status Reports)."

   The work status report was conducted as a part of the examinations coded 99456-W5-NM and 99546-W8-RE outlined in 28 Texas Administrative Code §134.204(k).

   - 28 Texas Administrative Code §134.204(k) states "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, per 28 Texas Administrative Code §134.204(k), the report is included and reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is not 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

		4/5/2017
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.