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
Aaron Smith, D.C.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-19-4606-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
June 24, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 SP PAYS $50.00 PER UNIT"

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Documentation supports the Designated Doctor referred out to additional testing which was necessary to complete the exam. 99456-SP modifier is billed when incorporating one or more specialists' reports(s) information into the final assignment of the MMI/IR exam per Rule 134.250 (I)(II)."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 30, 2018	Designated Doctor Examination – Specialist Report	$50.00	$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 §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
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.
- Denied in accordance with DWC rules and/or medical fee guideline including current CPT code 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

Is the requestor entitled to additional reimbursement?

Findings

Aaron Smith, D.C. is seeking reimbursement for incorporating the report from an MRI of the right knee into the determination of maximum medical improvement and impairment rating examination performed on July 30, 2018. The service was billed with procedure code 99456-W5-SP.

When the examining doctor refers testing for **non-musculoskeletal** body area(s) to a specialist, then the examining doctor shall bill using the appropriate MMI CPT code with modifier "SP" and indicate one unit in the units column of the billing form and be reimbursed $50.00.[1]

Because the testing in question was for a **musculoskeletal** body area, Dr. Smith is not entitled to additional reimbursement for the disputed service.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	August 29, 2019
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 Rule §133.307, effective May 31, 2012, *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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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. **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.

[1] 28 Texas Administrative Code §134.250(4)(D)(iii)(I)