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
UNIMED HEALTHCARE INC

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-20-0153-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
September 16, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of adjudication.

Amount in Dispute: $1,050.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed $1,050.00 for providing determinations of MMI and IR at the request of the treating doctor … The requestor billed the MMI/IR exams with code 99456, the code Rule 134.204(j)(3)(B)(ii) and (C) states should be billed by a referred doctor from the treating doctor.

However, the requestor billed Texas Mutual for a functional capacity evaluation on 2/1/19. Texas Mutual paid this on 4/8/19 … Section (j)(3)(B)(i)(A) indicates that if the referred doctor previously treated the injured employee then the coding should be 99455 with the appropriate modifier."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 14, 2019	99456-WP 99456-RE 99456-RE-59	$1,050.00	$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 (DWC).

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.
   - CAC-4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 714 – Accurate coding is essential for reimbursement, CPT/HCPCS billed incorrectly. Corrections must be submitted w/i 95 days from DOS.
   - 732 – Accurate coding is essential for reimbursement. Modifier billed incorrectly or missing. Services are not reimbursable as billed.
   - 892 – 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.
   - 891 – No additional payment after reconsideration

Issues

Is Unimed Healthcare, Inc. (Unimed) entitled to reimbursement of the services in dispute?

Findings

Unimed is seeking reimbursement for examinations performed on March 14, 2019. The insurance carrier denied the services in question, based in part on billing codes.

In its position statement, Texas Mutual Insurance Company argued that the health care provider had previously performed a functional capacity evaluation for the patient. Submitted evidence supports this statement.

If a doctor referred by the treating doctor has previously treated the injured employee, examinations to determine maximum medical improvement and impairment rating are billed using procedure code 99455.[1] No evidence was found to support that Unimed submitted a bill for this code.

The documentation received did not support that any other examinations were performed. The DWC finds that Unimed is not entitled to reimbursement for the disputed services.

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	January 9, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §134.250 (3)

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.