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
THOMPSON, DANIEL OTHA III

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-20-1750-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 17, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual Insurance Company has refused to pay me for incorporating additional testing necessary for completing the MMI/IR ordered and scheduled by the Division."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider referred out for additional diagnostic/radiology testing, which is included as part of the treatment plan necessary to determine MMI/IR. Per TAC Rule 134.210(e)(8) 'SP, specialty area—This modifier shall be added to the appropriate MMI CPT code when a specialty area is incorporated into the MMI report', Dr. Thompson did not refer out to another specialist in order to incorporate their report into his exam."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 18, 2019	99456-SP	$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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.210 sets out the guidelines regarding modifiers for division-specific services.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217 – The value of this procedure is included in the value of another procedure performed on this date.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - DC4 – No additional reimbursement allowed after reconsideration.
   - 892 – Denied in accordance DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

Issues

Is Daniel O. Thompson, III, M.D. entitled to additional reimbursement?

Findings

Dr. Thompson is seeking an additional reimbursement of $50.00 for incorporating additional testing into the designated doctor examination to determine maximum medical improvement and impairment rating. Dr. Thompson billed this service using procedure code 99456-SP.

Modifier "SP" is added to procedure code 99456 when the examining doctor incorporates a specialist report into the determination of impairment rating for a non-musculoskeletal body area.[1] Dr. Thompson provided no evidence to support that he referred the injured employee to a specialist or used information from a specialist's report into his final determination of the impairment rating of a non-musculoskeletal body area.

No additional reimbursement can be recommended.

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

		April 17, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §134.250 (4)(D)(iii)

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.