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
REYNOLDS, IAN JOHN

Respondent Name
UNITED AIRLINES INC

MFDR Tracking Number
M4-20-1836-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
March 30, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99455 is work related examination by the treating physician that includes completion of medical history,, performance of exam, formulation of diagnosis, plan for future medical treatment, completion of necessary documentation and report. Modifier TX appended to indicate treating physician."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The modifier 'TX' is used in DWC Rule 126.14 and only applies when the insurance carrier requests and schedules the Claimant to submit to an examination by the treating doctor to define the compensable injury. In this case, the Respondent did not ask Requestor to define the compensable injury, nor did Respondent schedule the examination."

Response Submitted by: Downs-Stanford, PC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 1, 2019	Examination by the Treating Doctor	$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 (DWC).

Background

1. 28 Texas Administrative Code §126.14 sets out the procedures for treating doctor examinations to define the compensable injury.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 306 – To reprice this code requires the appropriate modifier. Please attach the appropriate modifier and resubmit.
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - B13 – Re-evaluated; No additional payment is recommended.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is Ian J. Reynolds, M.D. entitled to reimbursement for the examination in question?

Findings

Dr. Reynolds is seeking reimbursement for an examination to define the compensable injury. The doctor billed this examination with procedure code 99455 and modifier "TX."

The Downs-Stanford, PC argued, on behalf of the insurance carrier, that

> The modifier 'TX' is used in DWC Rule 126.14 and only applies when the insurance carrier requests and schedules the Claimant to submit to an examination by the treating doctor to define the compensable injury. In this case, the Respondent did not ask Requestor to define the compensable injury, nor did Respondent schedule the examination.

The DWC agrees. No evidence was presented to support that the insurance carrier scheduled the examination in question or sent a written notice of the examination to the injured employee.[1] The DWC finds that Dr. Reynolds failed to support entitlement to the reimbursement for the examination in question. No reimbursement is 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 30, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §126.14 (b) and (c)

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.