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
ROMERO, FRED

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-2627-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 2, 2020

REQUESTOR'S POSITION SUMMARY

"… when a patient is going for a BRC hearing, the Extent can be done by simply MMI/IR evaluators if requested by OIEC which in this case it was requested by OIEC."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

"DWC69 confirms that Freddy Romero, DC, is the Doctor Selected by Treating, has not previously seen before. Dr. Romero is not the appointed DD per DWC, therefore payment for extent of injury was not paid."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 28, 2019	Examination to determine extent of injury (99456-W6)	$500.00	$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 §134.235 sets out the fee guidelines for examinations to determine extent of the compensable injury.
3. 28 Texas Administrative Code §134.240 sets out billing guidelines for designated doctor examinations.
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.

- 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.

Issues

Is Fred Romero, D.C. entitled to additional reimbursement for the examination in question?

Findings

Dr. Romero is seeking reimbursement for an examination to determine the extent of the compensable injury as requested by the injured employee's treating doctor. Dr. Romero billed this service with CPT code 99456-W6.

An examination to determine the extent of the compensable injury is billed using CPT code 99456 with modifier "W6" only when the examination was performed by a designated doctor ordered by the DWC.[1] No evidence was received to support that the examination in question was ordered by the DWC. No reimbursement is recommended for this 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

Signature	Medical Fee Dispute Resolution Officer	August 6, 2020 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 TAC §134.240 (1)(C)