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
GRANT MCKEEVER, MD

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-12-3168-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
JUNE 21, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The above referenced designated doctor performed the MMI examination and assigned the IR, but he did not perform the range of motion, strength, or sensory testing of the musculoskeletal body area(s), that means he should bill using the appropriate MMI CPT code 99456 with the component modifier -26. Reimbursement for the examining doctor is 80% of the MAR. The physical therapist and/or health care provider other than the examining doctor that performs the range of motion, strength, or sensory testing of the musculoskeletal body, the physical therapist and/or health care provider will bill with the component – TC. In this instance, reimbursement to the physical therapist and/or health care provider is 20% of the MAR. The bills from the two parties must be coordinated and billed appropriately and should be billed at the same time for the correct reimbursement."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The claimant received a significant 3rd part settlement in 2011. Texas Mutual issued a PLN-11 on 8/30/11 disputing liability for income and medical benefits due to the settlement (Attachment) The claimant's attorney sought and obtained an Order for a designated doctor examination on December 2011. The exam was carried out 3/7/12. Texas Mutual denied payment of the requestor's billing based on the PLN-11 and communicated this to the requestor through the explanation of benefits. Texas Mutual maintains that position still. Both the claimant and attorney knew well in advance of 3/7/12 their responsibility regarding payment of the designated doctor exam."

Response Submitted by: Texas Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 7, 2012	CPT Code 99456-W5-26 MMI/IR Evaluation Professional Services	$640.00	$0.00
	CPT Code 99456-W5-TC MMI/IR Evaluation Technical Services	$160.00	$0.00

TOTAL		$800.00	$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. Texas Labor Code §417.002 outlines the process for recovery in third-party settlements.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Per DWC Rules 133.10, 133.20 and clean claim guide instructions for completing the CMS-1500 professional license type, number and jurisdiction of the individual HCP who rendered the health care is required.
   - CAC-215-Based on subrogation of a third party settlement.
   - 871-Payment is being withheld because claimant received a third party settlement
   - 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 insurance carrier's reason for denial of payment supported?

Findings

The insurance carrier denied disputed services with claim adjustment reason code "215."

Texas Labor Code §417.002(a-c), RECOVERY IN THIRD-PARTY ACTION states

> The net amount recovered by a claimant in a third-party action shall be used to reimburse the insurance carrier for benefits, including medical benefits, that have been paid for the compensable injury. (b) Any amount recovered that exceeds the amount of the reimbursement required under Subsection (a) shall be treated as an advance against future benefits, including medical benefits, that the claimant is entitled to receive under this subtitle. (c) If the advance under Subsection (b) is adequate to cover all future benefits, the insurance carrier is not required to resume the payment of benefits. If the advance is insufficient, the insurance carrier shall resume the payment of benefits when the advance is exhausted.

The Division reviewed the submitted documentation and finds:

- No documentation was submitted to refute the carrier's position that the service in dispute are subject to payment from a third-party settlement; and
- No documentation was found to support that the net amount recovered in the settlement was exhausted.

The Division concludes that the requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00. The Division emphasized that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. Even though all the evidence was not discussed, it was considered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		07/23/2015
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 28 Texas Administrative Code §133.307, 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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division 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 with the Division. **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.