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 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BENJAMIN NGUYEN

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-2908-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 19, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please accept the attached claim for ***RECONSIDERATION/APPEAL*** for payment at this time for the following rationale.

NON PAYMENT FOLLOWING CARRIER'S RECEIPT OF INITIAL SUBMISSION."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 3/5/2014. The requestor, selected by the treating doctor, performed MMI and IR exams of the claimant and found the claimant not to be at MMI. (Attachment) The requestor billed Texas Mutual for this with code 99456-W5-NM."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 15, 2014	CPT Code 99456-W5-NM	$350.00	$350.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
    - CAC-4 – THE PROCEDURE CODE IS INCOSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING
    - 732 – ACCURATE CODING IS ESSENTIAL FOR REIMBURSEMENT. MODIFIER BILLED INCORRECLTY 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-W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824

Issues

1. Were the disputed services billed appropriately in accordance with 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. Review of submitted documentation finds the Treating Doctor was required to perform a maximum medical improvement evaluation. Review of maximum medical improvement evaluation report indicates the injured employee was not at maximum medical improvement (MMI). Therefore, the reimbursement for the disputed service performed is in accordance with 28 Texas Administrative Code 134.204(j)(3)(B)(ii)(C).

   The maximum allowable reimbursement for CPT Code 99456 W5-NM is $350.00
2. Review of the submitted documentation finds that additional reimbursement of $350.00 is allowed. The respondent paid $0.00. Based upon the documentation submitted, additional reimbursement in the amount of $350.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $350.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $350.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		11/26/14
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, 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 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 MDR 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.