**Texas Department of Insurance**
**Division of Workers' Compensation**
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## GENERAL INFORMATION

**Requestor Name and Address**

EMILE FARES, MD
3100 TIMMONS LANE, STE 250
HOUSTON, TEXAS 77027

**Respondent Name**
TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**
Box Number 54

**MFDR Tracking Number**
M4-11-2208-01

## REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "CARRIER REFUSES TO PAY CLAIM IN FULL FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION HAS BEEN SUBMITTED."

**Amount in Dispute:** $150.00

## RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "The requestor has not shown how or why it believes it is entitled to an additional $150.00."

**Response Submitted by:** Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

## SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| November 15, 2010 | 99456-W5-WP | $150.00 | $0.00 |

## 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 Medical Fee Guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 28, 2010
   - CAC-W1 – WORKER COMPENSATION SATE FEE SCHEDULE ADJUSTMENT

- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.

Explanation of benefits dated January 18, 2011

- CAC-W1 – WORKER COMPENSATION SATE FEE SCHEDULE ADJUSTMENT
- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICAL FEE GUIDELINE.
- 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. FOR INFORMATION CALL 1-800-937-6824

**Issues**

1. Has the Designated Doctor Examination (DDE) been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement under 28 Texas Administrative Code §134.204?

**Findings**

1. The provider billed the amount of $650.00 for CPT code 99456-W5-WP for a Designated Doctor (DD) examination for Maximum Medical Improvement/Impairment Rating (MMI/IR). Review of the documentation supports that MMI was assigned and one body area was rated. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I), the MAR for an IR using Diagnosis Related Estimates (DRE) method on lumbar spinal region is $150.00. The combined MAR for the MMI/IR services rendered is $500.00. The Respondent paid $500.00 for the MMI/IR.
2. Reimbursement of an additional amount is not recommended by the Division.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

## *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**

| Signature | Gregory Fournerat<br>Medical Fee Dispute Resolution Officer | October 11, 2011<br>Date |
|---|---|---|

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**