



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

THOMAS DILGER JR MD

Respondent Name

GREAT AMERICAN ALLIANCE INSURA

MFDR Tracking Number

M4-13-0167-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 18, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim should be paid with 150 days of interest since it was a Designated Doctor Exam faxed to Great American Alliance on 4/2/12, but was only partially paid for services rendered."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This is a medical fee dispute concerning service date March 27, 2012. A clerical error (\$1.50 rather than \$150.00) in the bill processing resulted in an underpayment of \$148.50. Carrier is processing payment for this additional reimbursement. This should resolve any issue with the reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 27, 2012	CPT Code 99456-WP-W5	\$150.00	\$2.11

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

- 28 Texas Administrative Code §134.130 sets out the procedures for Interest for Late Payment on Medical Bills and Refunds.
- 28 Texas Administrative Code §133.240 sets out the procedures for Medical Payments and Denials.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
- Texas Labor Code §413.019 sets out the procedures for Interest Earned For Delayed Payments, Refund, Or Overpayment.
- Texas Labor Code §401.023 sets out the procedures for Interest or Discount Rate.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 45 – Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement

- 397 – Allowance is based on utilization review pre-authorization

Issues

1. What is the Maximum Allowable Reimbursement (MAR) for disputed service code 99456-WP-W5?
2. What is the interest due per 28 Texas Administrative Code §134.130?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I) states “\$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.” In order for the provider to be reimbursed in accordance with §134.204(j)(4)(C)(ii)(I), the provider in this case, was required to perform a full physical evaluation with diagnosis related estimate (DRE) to the body area. The Division concludes that the impairment rating to the body area using diagnosis related estimate (DRE) method is allowed at \$150.00 in accordance with the requirements of 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(I). Documentation provided by the provider received on December 01, 2012 indicates insurance carrier made a payment in the amount of \$148.50 on October 19, 2012; therefore, no additional amount is due for CPT Code 99456-WP-W5.
2. The requestor states in its additional documentation provided on December 01, 2012 that interest is owed. Therefore, the requestor is owed an additional amount of \$2.11 for interest in accordance with 28 Texas Administrative Code 134.130.
3. Review of the submitted documentation finds that the respondent reimbursed the requestor \$0.00 for interest. In accordance with 28 Texas Administrative Code 134.130, the requestor is entitled to \$2.11 for interest owed.

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 \$2.11.

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 \$2.11 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

11/21/14

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.