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 and Address

DELBERT L MCCAIG DO
12407 N MOPAC EX STE 250-295
AUSTIN TX 78758

Respondent Name
WAL MART ASSOCIATES INC

Carrier's Austin Representative Box
Box Number 53

MFDR Tracking Number
M4-13-1967-01

MFDR Date Received
April 04, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was billed in error: a corrected CMS-1500 is attached. This claim was for a Division ordered Designated Doctor Exam. We billed a total of $3,950.00 for this claim but were paid $1,350.00. The explanation given on the EOB justifying the denial states: *WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.* The reduction of parts of this claim is in violation of the rules of the Texas Department of Insurance Division of Workers' Compensation as this service was ordered on the DWC-32."

Amount in Dispute: $25.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please see the attached EOB and reconsideration EOB's along with CMS form 1500s. No additional allowance, is recommended at this time."

Response Submitted by: Arkansas Claims Management, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 07, 2012	CPT Code 99456-W8-RE	$25.00	$25.00

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 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 16, 2012

   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 309 – The Charge for this procedure exceeds the fee schedule allowance

   Explanation of benefits dated October 08, 2012

   - W3 – Additional payment made on appeal/reconsideration
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time

   Explanation of benefits dated March 18, 2013

   - 193 - Original payment decision is being maintained. This claim was processed properly the first time
   - 5375 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

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

Findings

1. The dispute relates to a request for designated doctor examination which reimbursement is in accordance with 28 Texas Administrative Code §134.204 states "(2) When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection .. (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section and (k) The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier "RE." In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee." Review of the submitted documentation finds DWC-69, Report of Medical Evaluation, certified by Delbert McCaig (Designated Doctor selected by TDI-DWC). In review of the report provided by Designated Doctor Delbert McCaig, the doctor addressed Maximum Medical Improvement (MMI), Impairment Rating (IR), Return to Work (RTW), Disability and other similar issues with three body areas being rated. Review of the submitted medical bill finds the health care provider billed the disputed services under CPT Code 99456-W8-RE. Disputed CPT Code 99456-W8-RE is supported. The division finds the disputed services were billed in accordance with 28 Texas Administrative Code §134.204.

2. The respondent issued payment in the amount of $125.00. Based upon the documentation submitted, additional reimbursement in the amount of $25.00 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

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 $25.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March 28, 2014
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.