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
J THOMAS DILGER MD

Respondent Name
MIDWEST EMPLOYERS CASUALTY CO

MFDR Tracking Number
M4-13-2239-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 03, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a Designated Doctor Exam performed on 6/13/12. Despite multiple attempts to collect on this claim, the insurance carrier is attempting theft of services rendered. The DDE & claim were faxed to the carrier on 6/16/12."

Amount in Dispute: $950.00 plus interest

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier has paid the amount in dispute. Please dismiss"

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 13, 2013	Maximum Medical Improvement and Impairment Rating Evaluation	$950.00 plus interest	$26.15

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 §134.130 sets out the procedures for Interest for Late Payment on Medical Bills and Refunds.
2. 28 Texas Administrative Code §133.240 sets out the procedures for Medical Payments and Denials.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
5. Texas Labor Code §413.019 sets out procedures for Interest Earned for Delayed Payment, Refund, or Overpayment regarding medical services and fees.
6. Texas Labor Code §401.023 sets out the procedures for Interest or Discount Rate.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - W1 – Workers Compensation state fee schedule adjustment

Issues

1. What is the maximum allowable reimbursement for disputed procedure code 99456-W5-WP?
2. Is the requestor entitled to reimbursement for interest accrued for disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204(j)(3)(C) states "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350."

   Review of documentation provided supports the service billed for maximum medical improvement evaluation is in accordance with 28 Texas Administrative Code §134.204(j)(3)(C). The provider billed with 99456-WP-W5 in the amount of $350.00 with one unit billed.

   Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II) states "If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area."

   Review of submitted documentation finds impairment rating evaluation performed to three body areas (lumbar, spine and hip) using range of motion method. The provider billed with 99456-WP-W5 with one unit in the amount of $300.00, 99456-WP-W5 in the amount of $150.00 with one unit and 99456-WP-W5 in the amount of $150.00 with one unit. Therefore, the service billed of 99456-WP-W5 is supported.

   The total combined maximum allowable reimbursement for maximum medical improvement and impairment rating evaluation is $950.00.

   However, the respondent provided an explanation of benefit dated May 17, 2013 supporting payment in the amount of $950.00 to the requestor for the disputed service of maximum medical improvement and impairment rating evaluation.
2. Per 28 Texas Administrative Code §134.130 additional reimbursement is due for interest in the amount of $26.15.
3. The respondent issued payment in the amount of $950.00 for maximum medical improvement and impairment rating evaluation but no reimbursement for interest. Based upon the documentation submitted, additional reimbursement in the amount of $26.15 is recommended for interest.

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 $26.15.

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 $26.15 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Sandra Hernandez Medical Fee Dispute Resolution Officer	11/20/15 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.