



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

ARCH INSURANCE CO

MFDR Tracking Number

M4-13-2242-01

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 6/5/12. Despite multiple attempts the insurance carrier is attempting theft of services rendered. The DDE & claim were faxed to the carrier on 6/9/12. Therefore MDR is filed via certified mail with receipt."

Amount in Dispute: \$650.00 plus interest

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has paid the disputed amount .Please dismiss."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 05, 2012	Maximum Medical Improvement and Impairment Rating Evaluation	\$650.00 plus interest	\$18.41

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 procedures for Interest Earned for Delayed Payment, Refund, or Overpayment regarding medical services and fees.
- 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:
 - W1 – Workers compensation state fee schedule adjustment

Issues

1. What is the maximum allowable reimbursement for the disputed service of CPT Code 99456-WP-W5?
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 submitted documentation supports service billed for CPT 99456-WP-W5 in the amount of 350.00 with one unit billed for maximum medical improvement evaluation.

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.”

Per 28 Texas Administrative Code §134.204(j)(4)(C)(iii) states “If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR.”

Review of submitted documentation supports service billed for CPT Code 99456-WP-W5 for the amount of \$300.00 with one unit for impairment rating evaluation to one body area using range of motion method.

The total combined maximum allowable reimbursement for maximum medical improvement and impairment rating evaluation performed on June 05, 2012 is \$650.00.

The Division received an explanation of benefit from the respondent supporting payment in the amount of \$650.00 reimbursed to the requestor on May 17, 2013.

2. Per 28 Texas Administrative Code §134.130 additional reimbursement is due for interest in the amount of \$18.41.
3. Review of the submitted documentation finds the respondent issued payment in the amount of \$650.00 for maximum medical improvement and impairment rating evaluation, no reimbursement made to the provider for interest owed. Based upon the documentation submitted additional reimbursement in the amount of \$18.41 is recommended to the requestor for interest.

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 \$18.41.

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 \$18.41 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	2/27/15 Date
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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.