



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

BISHARA NABIL

**Respondent Name**

NEW HAMPSHIRE INSURANCE CO

**MFDR Tracking Number**

M4-13-2368-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

MAY 16, 2013

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "The enclosed claim was reduced in error. This claim was for a Division ordered Designated Doctor Exam. We billed a total of \$2,350.00 for this claim but were paid only \$500.00. The explanation given on the EOB justifying the denial states: *THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED / THIS PROCEDURE IS INCLUDED IN ANOTHER PROCEDURE PERFORMED ON THIS DATE*; however, this is incorrect. 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:** \$150.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "AIG has reviewed the Medical Fee Dispute Resolution Request/response (DWC-60). In reviewing the report, it is the carrier's position that the bill was paid correctly. The designated doctor did not perform any range of motion on the examination as shown in the narrative report. This doctor also billed for extent of injury, but did not address extent of injury and was not asked by DWC to address extent of injury."

**Response Submitted by:** AIG

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 08, 2012	CPT Code 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the medical fee guidelines for workers compensation specific services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 97 – The benefit for this services is included in the payment/allowance for another service/procedure that has

already been adjudicated

- 2 – This procedure is included in another procedure performed on this date
- 2 – The charge for this procedure exceeds the fee schedule allowance
- 3 – This procedure is included in another procedure performed on this date
- 3 - Services not documented in patient's medical records

**Issues**

1. Did the requestor perform any method for the impairment rating examination that was requested?
2. Is the requestor entitled to reimbursement?

**Findings**

1. 28 Texas Labor Code §134.204 states “ (B) If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. (3) The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.”

Review of the submitted documentation finds a Designated Doctor Examination Report which in the report it mentioned that the Designated Doctor Nabil Bishara addressed the issues of Maximum Medical Improvement and Impairment Rating, however Designated Doctor Nabil Bishara indicated in the report that the injured worker has 0% whole person impairment with no method of rating performed. Also the DWC-69 is documented and certified by Nabil Bishara which in section IV, box b is marked which states “I certify that the employee has permanent impairment as a result of the compensable injury. The amount of permanent impairment is 0%, which was determined in accordance with the requirements of the Texas Labor Code and Texas Administrative Code.”

Therefore, CPT Code 99456-W5-WP is not supported.

2. The respondent issued payment in the amount of \$0.00. Based upon the documentation submitted, no additional reimbursement is recommended.

**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**

_____	_____	4/11/14
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.**