



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 MD

Respondent Name

AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number

M4-14-0138-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 12, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a Designated Doctor Exam performed on 9/5/12. Despite multiple attempts to collect on this claim, the insurance carrier is attempting heft of services rendered. The DDE & claim were faxed to the carrier on 9/11/12. Therefore MDR is field via certified mail with receipt."

Amount in Dispute: \$650.00 + interest

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This in a medical fee dispute concerning a designated doctor exam with Requestor on September 5, 2012. Carrier is processing payment with accrued interest. Carrier will supplement this response with payment documentation."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 05, 2012	CPT Code 99456-WP-W5	\$650.00 + interest	\$22.11

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.
- Texas Labor Code §413.019 sets out the 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
- 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.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - No explanation of benefits

Issues

1. What is the maximum allowable reimbursement for the disputed service 99456-WP-W5?
2. Is the requestor entitled to interest for the disputed service?
3. Is the requestor entitled to additional 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.” In order for the requestor to be reimbursed in accordance with 28 Texas Administrative Code §134.204(j)(3)(C), the requestor in this case was required to perform a maximum medical improvement examination. Review of submitted documentation finds the requestor performed a maximum medical improvement examination. The reimbursement for maximum medical improvement CPT Code 99456-WP-W5 is \$350.00.

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.” In order for the requestor to be reimbursed in accordance with 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(-a-), the requestor in this case was required to perform a full physical impairment evaluation with range of motion. Review of submitted documentation finds the requestor performed a full physical impairment evaluation with range of motion to the upper extremity. The reimbursement for the impairment rating evaluation is \$300.00 in accordance with 28 Administrative Code §134.204(j)(4)(C)(ii)(II)(-a-).

The total maximum allowable reimbursement for CPT Code 99456-WP-W5 is \$650.00.

Per additional documentation provided from the requestor on April 03, 2014 states partial payment received on October 17, 2013 and interest is accruing.

Therefore, no additional reimbursement is due for CPT Code 99456-WP-W5.

2. Per 28 Administrative Code §134.130 reimbursement is due in the amount of \$22.11 for interest.
3. The division concludes that reimbursement for interest is \$22.11. The respondent issued payment in the amount of \$0.00 for interest. Based upon the documentation submitted, additional reimbursement in the amount of \$22.11 is recommended.

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 \$22.11.

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 \$22.11 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	11/26/14 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.