



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

Respondent Name

CITY OF AUSTIN

MFDR Tracking Number

M4-14-1024-01

Carrier's Austin Representative

Box Number 43

MFDR Date Received

December 04, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a Designated Doctor Exam performed on 2/21/13. 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 2/26/13 X4& 3/2/13. Therefore, MDR is field via certified mail with receipt."

Amount in Dispute: \$500.00 + interest

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "After review of our bill review system, there has been no receipt of the medical bill for DOS 2/21/13. This MFDR was our first receipt of medical bill. There are no logged phone calls to show Dr. Dilger attempted to check status on receipt of the bills he supposedly faxed multiple items. Had his office contacted the third party administrator(TPA) to check status, they would have been notified at that time, there was no bill on file for DOS 2/21/13. We are allowing \$500.00 for the exam performed 2/21/13."

Response Submitted by: JI Specialty Services, Inc

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 2013	CPT Code 99456-RE-W6 (Extent of Injury Examination)	\$500.00 + interest	\$12.38

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 the procedures for Interest Earned For Delayed Payments, Refund, Or Overpayment.
- 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:

- No explanation of benefits received

Issues

1. What is the allowable reimbursement for disputed service code 99456-RE-W6?
2. What is the interest due per 28 Texas Administrative Code §134.130?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204(k) states “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 documentation provided finds the requestor performed extent of injury examination for date of service February 21, 2013. The total maximum allowable reimbursement is \$500.00
Carrier has provided an explanation of benefit dated December 17, 2013 showing payment made in the amount of \$500.00 for disputed service 99456-RE-W6. The requestor also provided additional documentation dated April 01, 2014 indicating payment paid on December 31, 2013. Therefore, no additional reimbursement is allowed.
2. Per 28 Texas Administrative Code §134.130 the amount of \$12.38 for interest is due.
3. The division concludes that the total allowable for reimbursement of \$12.38 for interest is recommended. The respondent made a payment in the amount of \$0.00 for interest. Based upon the documentation submitted, additional reimbursement in the amount of \$12.38 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 \$12.38.

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 \$12.38 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		11/20/2014
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.