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
Ronald LaVoie, DC

Respondent Name
Commerce and Industry Insurance

MFDR Tracking Number
M4-14-2772-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 9, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The following bill was audited and paid incorrectly. TDI-DWC addresses Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations with Rule 134.204, Subsection (k). The Rule states **the reimbursement shall be $500.00 in accordance with subsection (i).** This section also states **testing shall be billed using the appropriate CPT codes & reimbursed in addition to the examination fee.** As well, under rule 134.204, Subsection (i)(2) states the first examination shall be reimbursed at 100% of the fee outlined in (k), the second at 50% and subsequent examination at 25%."

Amount in Dispute: $375.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on May 19, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2014	Designated Doctor's Exam to Determine Injured Employee's Ability to Return to Work	$375.00	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 (k) defines how much a Return to Work exam should be reimbursed and what documentation is required to accompany the exam.

3. 28 Texas Administrative Code §127.10 (e) explains what documentation must accompany a Return to Work evaluation by a Designated Doctor.
4. 28 Texas Administrative Code §129.5 (c) addresses what is required for a DWC073 form to be considered complete.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1 – (W1) Workers Compensation State Fee Schedule Adjustment
   - 1 – No Reduction Available. (VRNA)
   - 2 – (16) Claim/service lacks information or has submission/billing error(s) which is needed for adjudication
   - 2 – The amount paid reflects a fee schedule reduction. (P300)
   - 3 – The charge for this procedure exceeds the fee schedule allowance. (Z710)
   - 4 – This procedure was reduced to 25 percent of the primary procedure per guidelines. (M479)

Issues

1. Did the requestor bill for the disputed service in accordance with 28 Texas Administrative Code §134.204 (k)?
2. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (k) states, "…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**" [emphasis added].

   28 Texas Administrative Code §127.10 (e) states, "A designated doctor who examines an injured employee pursuant to any question relating to return to work is required to file a Work Status Report that meets the required elements of these reports described in §129.5 of this title (relating to Work Status Reports)."

   28 Texas Administrative Code §129.5 (c) states, "The doctor shall be considered to have filed a complete Work Status Report if the report is filed in the form and manner prescribed by the Commission, signed, and contains at minimum: (1) **identification of the employee's work status**; (2) **effective dates and estimated expiration dates of current work status and restrictions** …" [emphasis added].

   The healthcare provider filed a Work Status Report (DWC073), but it cannot be considered complete, as it does not identify the employee's work status or effective/estimated expiration dates of work status. This information was also not addressed in the narrative report. Therefore the submission did not meet the requirements of 28 Texas Administrative Code §134.204 (k).
2. Because required information was missing from the bill submission, the requestor is not entitled to additional reimbursement.

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

	Laurie Garnes	December 23, 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.