



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

ADAM W RACUSIN MD

Respondent Name

TWIN CITY FIRE INSURANCE CO

MFDR Tracking Number

M4-14-3402-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

July 15, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We requested a reconsideration from the insurance, Hartford Insurance, for a claim on patient [injured employee], for date of service 04/17/2014 in the amount of \$1,465.00, for a Designated Doctor Exam. We did receive payment for \$1,1165.00. We submitted a reconsideration request on 06/18/2014, for the balance of \$300.00 **The denial reason(s) per EOB are: W1, 4150.**"

Amount in Dispute: \$300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation has found that billing was reimbursed in accordance with Rule 134.204(j)(2). As per the Provider's documentation (DWC 069), the employee did not reach MMI at that time, thus, the MMI portion only is to be billed and reimbursed."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 17, 2014	CPT Code 99456-W5-WP	\$300.00	\$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 sets out the fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – Workers Compensation State Fee schedule adjustment
 - 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(J) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed
 - W3 – Additional payment made on appeal/reconsideration
 - 193 – Original payment decision is being maintained. This claim was processed properly the first time

- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance

Issues

1. Is the requestor entitled to reimbursement?

Findings

1. In this case the requestor was required to evaluate the injured employee for maximum medical improvement, impairment rating, extent of injury and return to work. The following procedure code in dispute is 99456- W5- WP for impairment rating. Review of documentation provided supports the requestor examined the injured employee for maximum medical improvement, extent of injury and return to work examination. Review of submitted report does not support impairment rating evaluation with range of motion performed. Therefore, no additional reimbursement is recommended in accordance with 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(-a-).

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

_____	_____	12/10/14
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.