



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

David Loper, DC

Respondent Name

Old Republic Insurance Company

MFDR Tracking Number

M4-15-0767-01

Carrier's Austin Representative

Box Number 44

MFDR Date Received

October 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I would like to request assistance in obtaining the balance for the service provided on 01/30/2014. An attempt was made to the carrier in a request for reconsideration. The response was an EOB stating that The benefit for this service is included in the payment /allowance for another service/procedure that has already been adjudicated. The bill reviewer did not use the Tier Reimbursement method correctly. The second line item should have been paid at 100%.

...The DWC asked for the Maximum Medical Improvement and Impairment rating and Return to work to be address. As outline in TLC/DWC rule 134.204(j). Multiple examinations under the same specific Division order are performed concurred (other than MMI/IR) The line item 99456 RE W8 was paid incorrectly. It should have paid at 100%. The line item 99080 Modifier 73 should have been paid (\$15.00) according to TLC/DWC rule 127.10 and 129.5..."

Amount in Dispute: \$190.00

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 November 6, 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 30, 2014	Designated Doctor Examination	\$190.00	\$175.00

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 §133.240 sets out the requirements for processing medical bills.
3. 28 Texas Administrative Code §134.204 sets out the procedures for billing and reimbursing Designated Doctor Examinations.
4. 28 Texas Administrative Code §127.10 sets out general procedures for Designated Doctor Examinations.
5. 28 Texas Administrative Code §129.5 sets out the procedures relating to Work Status Reports.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 59 – Processed based on multiple or concurrent procedure rules.
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
 - P1 – This code was not defined as required by 28 Texas Administrative Code §133.240 (f)(17)(H)

Issues

1. What is the correct MAR for CPT Code 99456-W8-RE according to 28 Texas Administrative Code §134.204?
2. Is the filing of the DWC-073 payable when provided in conjunction with 28 Texas Administrative Code §134.204 (i)?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204 (k), "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" [emphasis added]. The submitted documentation indicates that the Designated Doctor performed an examination to determine the injured employee's ability to Return to Work, but did not bill for any other examinations under 28 Texas Administrative Code §134.204 (i)(2). Therefore, the correct MAR for this examination is \$500.00.
2. Per 28 Texas Administrative Code §134.204 (l), "The following shall apply to Work Status Reports. When billing for a Work Status Report **that is not conducted as a part of the examinations outlined in subsections (i) and (j) of this section**, refer to §129.5 of this title (relating to Work Status Reports)" [emphasis added].
28 Texas Administrative Code §129.5 states, "...a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report **required under this section or for providing a subsequent copy** of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy" [emphasis added]. This section applies only to treating doctors and referral doctors, as stated earlier in the section. This examination was provided by a designated doctor. There is no evidence in the supplied documentation to support that the requestor was billing for a subsequent copy of a previously submitted Work Status Report.
Therefore, the filing of the DWC-073 is not payable when provided in conjunction with a Designated Doctor Examination under 28 Texas Administrative Code §134.204 (i).
3. Review of the submitted documentation finds that the requestor billed \$515.00 for the services in dispute. The insurance carrier paid \$325.00. The requestor is entitled to an additional reimbursement of \$175.00.

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 \$175.00.

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 \$175.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

January 21, 2015
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.