



# 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](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

Abdool Razack, MD

**Respondent Name**

City of Plano

**MFDR Tracking Number**

M4-15-0923-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

November 17, 2014

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "... New Rule §134.204(i) describes all six examinations performed by designated doctors, but directs the reimbursement for MMI/IR examinations performed by designated doctors to subsection (j), and excludes reimbursement for MMI/IR from the tiered reimbursement structure of subsection (i) for multiple examinations performed by the designated doctor. MMI/IR examinations performed by designated doctors do not result in the tiering of the non-MMI/IR examinations.

When conducting exams for issues other than MMI/IR, apply the new tiered reimbursement method described in rule 134.204(i) to the remaining four exams. **Reimbursement for one of these exams is \$500...**

**We seek full reimbursement for the outstanding balance of \$375.00** along with interest accrued according to Rule 134.803 Calculating Interest for Late Payments on Medical Bills."

**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 November 25, 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
March 31, 2014	99456-W8-RE	\$375.00	\$375.00

#### 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 procedures for billing and reimbursing Designated Doctor Examinations.
- 3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 1 – Workers Compensation State Fee Schedule adjustment TXW1

**Issues**

- 1. What is the correct MAR for CPT Code 99456-W8-RE according to 28 Texas Administrative Code §134.204?
- 2. 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. Review of the submitted documentation finds that the requestor billed \$500.00 for the services in dispute. The insurance carrier paid \$125.00. The requestor is entitled to an additional reimbursement of \$375.00.

**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 \$375.00.

**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 \$375.00 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	February 2, 2015 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.**