



# 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**

Ramesh D. Shah, MD

**Respondent Name**

American Zurich Insurance Company

**MFDR Tracking Number**

M4-15-1583-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

January 28, 2015

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "I received an EOB denying partial payment for this bill for a designated doctor exam performed on March 19, 2014; the denial states 'WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT; THE PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED OR A REQUIRED MODIFIER IS MISSING.' However, this denial is incorrect, since the procedures were correctly billed for services rendered, and the examination was performed in accordance with the exam requested by the insurance4 carrier found on the DWC32..."

We billed a total of \$3,550.00 for these services. *We have only received \$950.00 from your company, which does not meet the Medical Fee Guidelines suggested payment amount. Please issue prompt payment in the amount of \$2,600.00 to settle this claim.*"

**Amount in Dispute:** \$250.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "This letter is in regards to the Medical Dispute Request from Landmark Exams for payment for services rendered on 3/19/2014. The provider is stating that they are due additional monies totally \$250.00."

The original bill was received on 04/18/2014 and processed under review number 4792844 and finalized on 05/06/2014. The bill was for a Designated Doctor Exam billing \$3, 550.00. The original audit recommendation was for \$950.00 and denied services for not having the correct modifier or supporting documentation on the original bill.

A reconsideration for the date of service of 03/19/2014 was received on 10/30/2014 and finalized on 11/18/2014. The audit did allow any additional allowance totally \$200.00 under review number 5412781. The explanation on the audit stated the following, 'Line 3, ALLOWED PAYMENT OF \$200.00 AS LINE ONE WAS OVER PAID BY \$300.00.'

Line1-MMI \$350.00  
IR/ROM-\$300 (FOR ONE BODY AREA  
DOCUMENTATION DOESN'T SUPPORT LINE 2, 4 OR 5.

It appears the provider is seeking \$250.00 for CPT 99456-W8 (W8-DD exam for RTW-return to work). It does not show this being asked to be performed by TDI; according to the DWC-068. Review of records doesn't show it being addressed in the documentation. Original audit recommendation abides."

**Response Submitted by:** WellComp Managed Care Services

## **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 19, 2014	Designated Doctor Examination (RTW)	\$250.00	\$250.00

## **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 guidelines for billing and reimbursing Designated Doctor Examinations.
3. 28 Texas Administrative Code §127.5 sets out the procedures for scheduling Designated Doctor Examinations.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 16 – Claim/service lacks information which is needed for adjudication.
  - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.

### **Issues**

1. Was the disputed service ordered by the Division of Workers' Compensation according to 28 Texas Administrative Code §127.5?
2. Did the requestor correctly document the disputed services?
3. Is the requestor entitled to additional reimbursement?

### **Findings**

1. In the position statement, the insurance carrier states, "It does not show this [Return to Work (RTW)] being asked to be performed by TDI; according to the DWC-068." Review of available documents indicates that the Designated Doctor was asked to address Maximum Medical Improvement, Impairment Rating, Disability-Direct Result, and Return to Work. Therefore, the Division finds that the disputed service was ordered by the Division of Workers' Compensation according to 28 Texas Administrative Code §127.5.
2. The insurance carrier denied the disputed services stating, "Claim/service lacks information which is needed for adjudication." Further, the insurance carrier stated in the position statement, "Review of records doesn't show it [RTW] being addressed in the documentation." Review of the submitted documentation finds that RTW was addressed on page 9 of the Designated Doctor narrative report and the narrative was accompanied by a DWC-073 as required by 28 Texas Administrative Code §134.204 (k). Therefore, the Division finds that the requestor correctly documented the disputed services.
3. 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." Furthermore, 28 Texas Administrative Code §134.204 (i)(2) states, "When multiple examinations under the same specific Division order are performed concurrently under paragraph (1)(C) - (F) of this subsection: (A) the first examination shall be reimbursed at 100 percent of the set fee outlined in subsection (k) of this section; (B) the second examination shall be reimbursed at 50 percent of the set fee outlined in subsection (k) of this section; and (C) subsequent examinations shall be reimbursed at 25 percent of the set fee outlined in subsection (k) of this section." The submitted documentation indicates that the Designated Doctor performed examination to determine Disability and Return to Work as ordered by the Division.

Review of the submitted documentation finds that the insurance carrier paid \$500.00 for the examination to determine if disability was a direct result of the compensable injury. Therefore, the total allowable for the examination to determine the injured employee's ability to Return to Work is \$250.00. The insurance carrier paid \$0.00. Consequently, the requestor is entitled to an additional reimbursement of \$250.00.

**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 \$250.00.

**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 \$250.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

	Laurie Garnes	March 12, 2015
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.**