



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Robert Panzarella, M.D.

Respondent Name

ACE American Insurance Company

MFDR Tracking Number

M4-15-3782-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

July 20, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We received partial payment ... with a reduction of \$500.00 for RE-W7."

Amount in Dispute: \$1400.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment has been made."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: March 25, 2015, Designated Doctor Examination (Disability Direct Result), \$1400.00, \$500.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 guidelines for billing and reimbursing Division-specific services.
3. Texas Labor Code §408.0041 defines the procedures for designated doctor examinations.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- D96 - Denied-Non Authorized service
- P12 - Workers' compensation jurisdictional fee schedule adjustment.
- 790 - This charge was reimbursed in accordance to the Texas Medical Fee Guideline.

Issues

1. What are the disputed services?
2. Was the disputed service ordered by the commissioner in accordance with Texas Labor Code §408.0041?
3. Are the insurance carrier's reasons for denial or reduction of payment supported?
4. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor confirmed partial payment of \$900.00 for CPT codes 99456-W5-WP and 99456-RE-W8. The requestor confirmed that 99456-RE-W7 remains unpaid and in dispute. Therefore, this will be the only service considered.
2. The insurance carrier denied disputed service with claim adjustment reason code D96 – "DENIED-NON AUTHORIZED SERVICE." Texas Labor Code §408.0041 (h) requires that "The insurance carrier shall pay for: (1) an examination required under Subsection (a), (f), or (f-2), unless otherwise prohibited by this subtitle or by an order or rule of the commissioner." Review of the available information finds that the Division ordered a Designated Doctor Examination with the requestor to include disability as a direct result of the compensable injury. Therefore, the disputed service was ordered by the commissioner in accordance with Texas Labor Code §408.0041.
3. Submitted documentation does not support that the disputed services are prohibited by statute or by rule or order of the commissioner. Therefore, insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
4. 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." The submitted documentation indicates that the Designated Doctor performed an examination to determine if disability was a direct result of the compensable injury. Therefore, the correct MAR for this examination is \$500.00.

5. The total MAR for the disputed services is \$500.00. The insurance carrier paid \$0.00. Therefore, a reimbursement of \$500.00 is recommended.

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 \$500.00.

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 \$500.00 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

August 31, 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, 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 MFDR 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.