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
DR FERRAL L. ENSDLEY

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-19-0493-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
SEPTEMBER 28, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The original amount was billed in accordance to this rule. I billed a 99455 in which the MAR is $115.60, PLUS the impairment rating of either $150 or $300. We were only paid for the office visit even though the HCFA clearly states this was for an impairment rating."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In response to the request for reconsideration, the Carrier issued additional reimbursement. This reimbursement is the same as the reimbursement being sought in the Request for Medical Fee Dispute Resolution."

Response Submitted By: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 29, 2018	CPT Code 99455-V3-WP Maximum Medical Improvement (MMI) and Impairment Rating (IR) Evaluation	$150.00	$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, effective May 31, 2012, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §130.1, effective August 25, 2013, addresses MMI/IR evaluations.
3. 28 Texas Administrative Code §134.250, effective July 7, 2016, sets the reimbursement guidelines for Maximum Medical Improvement Evaluations and Impairment Rating Examinations.
4. 28 Texas Administrative Code §134.210, effective July 7, 2016, sets the fee guideline for Workers' compensation specific services.

5. The services in dispute were reduced/denied by the respondent with the following claim adjustment reason codes:
   - P12-Workers compensation jurisdictional fee schedule adjustment.
   - 309-The charge for this procedure exceeds the fee schedule allowance.
   - 863-Reimbursement is based on the applicable reimbursement fee schedule.
   - 947-Upheld. No additional allowance has been recommended.
   - W3-Additional payment made on appeal/reconsideration.
   - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - W3-In accordance with TDI-DWC rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

Is the requestor due additional reimbursement for CPT code 99455-W3-WP?

Findings

The Division makes the following conclusions based upon the information and documentation presented to the Division to date. Even though all the evidence was not discussed, it was considered.

1. Did the carrier reimburse Dr. Endsley for the disputed services?

On June 29, 2018, the claimant attended a MMI/IR evaluation by the treating doctor. The requestor billed the respondent $270.00 for code 99455-V3-WP. The respondent originally issued payment of $115.60 based the fee guideline. The requestor indicated that an additional payment of $150.00 is due for the impairment rating evaluation. The respondent wrote, "In response to the request for reconsideration, the Carrier issued additional reimbursement." The respondent included an EOB that indicates on October 11, 2018, the respondent paid $154.40 via check number 896D91580075.

The Division concludes that the carrier changed its original final action and decided to reimburse Dr. Endsley for the disputed amount.

For that reason, the Division moves to resolve this dispute with the information available and concludes that no additional reimbursement can be recommended.

Conclusion

The Division concludes that Memorial has already been paid for the service in dispute. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, and pursuant to Texas Labor Code Section 413.031, the division has determined that the requestor is not entitled to additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	01/17/2019 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.