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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Richard Williams, M.D.

Respondent Name
Travelers Indemnity Company

MFDR Tracking Number
M4-19-1446-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
November 14, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "$350.00 for exam + $300.00 for range of motion + $150.00 2nd body area … Specialist Report ($50.00) Total Reimbursement is $850.00 … We seek full reimbursement for the outstanding balance of $150.00 along with interest …"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… the Provider has been properly reimbursed for the disputed services, and no additional reimbursement is due."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 8, 2018	Designated Doctor Examination	$150.00	$0.00

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 §134.250 sets out the fee guidelines for examinations to determine the maximum medical improvement and impairment rating for a compensable injury.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 298 – The recommended allowance is based on the value for the professional component of the service performed.

- 600 – Allowance based on maximum number of units allowed per fee schedule guidelines and/or service code description.
- 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.
- 947 – Upheld. No additional allowance has been recommended.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Richard Williams, M.D. is seeking an additional reimbursement of $150.00 for a designated doctor examination performed on May 8, 2018.

The designated doctor is to bill an examination to determine maximum medical improvement with CPT code 99456 and modifier "W5."[1] Reimbursement is $350.00 for this examination.[2] The submitted documentation supports that Dr. Williams performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

The designated doctor is to bill an examination to determine the impairment rating of an injury with CPT code 99456 and modifier "W5."[3] Reimbursement is $300.00 for the first musculoskeletal body area.[4] The submitted documentation supports that Dr. Williams provided an impairment rating, which included a musculoskeletal body part, performing a full physical evaluation with range of motion of the upper extremity. Therefore, the MAR for this examination is $300.00.

A designated doctor may bill and be reimbursed for review of specialist reports when performing an impairment rating of a non-musculoskeletal body area.[5] Review of the submitted information does not support that Dr. Williams provided an impairment rating of a non-musculoskeletal body area. Additional reimbursement for this service cannot be recommended for this service.

The total MAR for the services in question is $650.00. The total reimbursement from the insurance carrier is $700.00. No additional reimbursement for the disputed services is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	January 15, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Codes §§134.250(3)(C) and 134.240(1)(B)
[2] 28 Texas Administrative Code §134.250(3)(C)
[3] 28 Texas Administrative Codes §§134.250(4)(A) and 134.240(1)(A)
[4] 28 Texas Administrative Codes §§134.250(4)(C)(ii)(II)(-a-)
[5] 28 Texas Administrative Codes §§134.250(4)(D)(iii)

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §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 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. **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.