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
Blessing Anyatonwu, D.C.

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-19-4122-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 13, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I'm still owed the remaining payment for determining Return to Work and Disability. Return to Work - $250 Disability - $125 For a total of $375."

Amount in Dispute: $375.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On line 1 of the bill we reimbursed the maximum allowed payment of the MMI (maximum medical improvement) portion of the charges and the IR (impairment rating) for the spine (ROM-range of motion testing). We also reimbursed the maximum allowed payment for the return to work examination. On line 2 of the bill, the provider only included modifiers W8 and RE for the return to work exam therefore it was reimbursed alone."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 7, 2019	Designated Doctor	$375.00	$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 §134.235 sets out the fee guidelines for examinations to determine the ability of the injured employee to return to work.
3. 28 Texas Administrative Code §134.240 sets out the fee guidelines for designated doctor examinations.

Issues

Is the requestor entitled to additional reimbursement for the services in question?

Findings

Dr. Anyatonwu is seeking additional reimbursement for a designated doctor examination performed on March 7, 2019. The insurance carrier paid a reduced reimbursement citing the fee guidelines.

Submitted evidence supports that Dr. Anyatanwu presented a medical bill for the examination to the insurance carrier with the following procedure codes and modifiers:

- 99456-W5-WP
- 99456-W8-RE

Procedure code 99456-W5-WP represents an examination to determine maximum medical improvement and impairment rating.[1] Per explanation of benefits dated May 3, 2019, the insurance carrier reimbursed $650.00. This was the full amount billed by Dr. Anatonwu.

Procedure code 99456-W8-RE represents an examination to determine the ability of the injured employee to return to work.[2] The maximum allowable reimbursement for this examination is $500.00.[3] Per explanation of benefits dated May 3, 2019, the insurance carrier reimbursed this amount.

No evidence was submitted to support that any additional procedure codes were submitted to the insurance carrier for reimbursement as argued by the health care provider. No further reimbursement is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the DWC 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 DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	June 17, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §134.240
[2] 28 TAC §134.235; 28 TAC §134.240
[3] 28 TAC §134.235

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.