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
Laura Deon, M.D.

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-19-4311-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 3, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION … **THE FIRST QUESTION IS BILLABLE AT $500 PER DOS FOR A DD EXAM, AND THE SECOND QUESTION IS BILLABLE AT $250.00."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "As noted on the DWC-60, the carrier reimbursed the provider $940. The provider is seeking additional reimbursement of $500. The carrier is going to reprocess the provider's bill."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2018	Designated Doctor Examination	$500.00	$250.00

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 §134.240 sets out the reimbursement procedures for designated doctor examinations.
3. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine extent of the compensable injury and ability to return to work.
4. The insurance carrier reduced payment for the disputed services citing fee guidelines.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Dr. Deon is seeking additional reimbursement for a designated doctor examination performed on September 8, 2018. Per explanations of benefits dated December 5, 2018, and June 26, 2019, the insurance carrier paid the total amount billed for CPT codes 99456-W5-WP, 99456-W7-RE, 99456-W8-RE, 99080-73, and 99456-W5-MI. Therefore, these services will not be considered in this dispute.

A balance of $250.00 remains unpaid for CPT code 99456-W6-RE. Per DWC contact dated July 26, 2019, Dr. Deon continues to seek this amount. The DWC will consider this service in the dispute.

The designated doctor is required to bill an examination to determine extent of injury with CPT code 99456 including modifiers "RE"[1] and "W6."[2] Reimbursement is $500.00 and includes DWC-required reports.[3] The submitted documentation supports that Dr. Deon performed an examination to determine extent of injury.

When multiple examinations under the same specific division order are performed at the same time under the same order, the first of multiple examinations that are not part of the examination for maximum medical improvement and impairment rating, it is reimbursed at 100 percent of the $500.00 noted above.[4]

Therefore, the total allowable amount for the examination in question is $500.00. The insurance carrier reimbursed a combined total of $250.00 for this examination. An additional reimbursement of $250.00 is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $250.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $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	September 19, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §134.235
[2] 28 TAC §134.240(1)(C)
[3] 28 TAC §134.235
[4] 28 TAC §134.240(2)(A)

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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.