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
Bellerive Medical Services PA

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-20-0244-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
September 26, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In brief, the patient was seen for a designated doctor evaluation. We received payment for $1,100.00; however, we are missing payment of $165.00 as allowed by the Texas Fee Guideline from the carrier."

Amount in Dispute: $165.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Upon notification of this dispute the Office performed a comprehensive review of the charges listed on the DWC 60 and found that payment in the amount of $150.00 had been previously made on 8/23/2019. However, the Office will maintain our denial for CPT 99080 -73 as pursuant to Rule 134.204 (k) this is Division required report and the reimbursement for 99456 W8 RE included Division required reports."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 18, 2018	Designated Doctor Examination to Determine Maximum Medical Examination and Impairment Rating	$150.00	$0.00
October 18, 2018	Work Status Report	$15.00	$0.00
	Total	$165.00	$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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.239 sets out the guidelines for work status reports as a part of the

examinations outlined in 28 Texas Administrative Codes §§134.240 and 134.250.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - W3 – Additional payment made on appeal/reconsideration.
   - B20 – Payment adjusted because procedure/service was partially or fully furnished by another provider.
   - 5080 – Based on the receipt of additional information and/or clarification, we are recommending further payment be made for the above noted procedure code(s).

Issues

1. Is Bellerive Medical Services PA entitled to additional reimbursement for billed code 99456-W5-WP?
2. Is Bellerive Medical Services PA entitled to additional reimbursement for billed code 99080?

Findings

1. Bellerive Medical Services PA is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating, billed with code 99456-W5-WP.

   Explanations of benefits dated November 14, 2018, and August 17, 2019, submitted to the DWC indicates that the insurance carrier paid a total of $500.00. This is the total amount billed by Bellerive Medical Services PA.

   No further reimbursement for this billed code is recommended.

2. Bellerive Medical Services PA is also seeking reimbursement for a Work Status Report, billed with code 99080. The filing of the DWC073 is not separately payable when provided in conjunction with a designated doctor examination performed.[1]

Conclusion

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	October 23, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §134.239

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.