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
WINTER-VALDEZ, CORNELIA PATRICIA

Respondent Name
TASB RISK MGMT FUND

MFDR Tracking Number
M4-21-1600-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
May 10, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Maximum Allowable Reimbursement (MAR) for a MMI / IR examination is equal to the reimbursement for the MMI evaluation plus the reimbursement for the body area(s) evaluated for assignment of an IR."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 5, 2021	Designated Doctor Examination (99456-W5-WP)	$300.00	$150.00

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 §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 282 – The insurance company is reducing or denying payment after reconsidering a bill.
   - 308 – MMI/IR procedure code 99456 is permitted only once in the same date of service.
   - 375 – Please see special *note* below.

- Notes: “Only one WP reimbursed for 99456 per Exam, because multiple Exam of WP can’t be reimbursed at the same visit.”
- 50 – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer
- P12 – Workers’ compensation jurisdictional fee schedule adjustment.
- 351 – No additional reimbursement allowed after review of appeal/reconsideration.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did TASB Risk Management Fund respond to the medical fee dispute?
2. Is the examination in question subject to dismissal based on medical necessity?
3. Is C. Patricia Winter, M.D. entitled to additional reimbursement for reimbursement?

Findings

1. The Austin carrier representative for TASB Risk Management Fund is Burns, Anderson, Jury and Brenner. The representative was notified of this medical fee dispute on May 18, 2021. If the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.[1]

   As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. Dr. Winter is seeking additional reimbursement for an examination to determine maximum medical improvement (MMI) and impairment rating (IR) ordered by the DWC. TASB Risk Management Fund denied payment based, in part, on medical necessity.

   The insurance carrier is required to reimburse designated doctor examinations unless otherwise prohibited by statute, order, or rule.[2] The insurance carrier submitted no evidence to support that reimbursement for the examination in question was prohibited. The DWC finds that the examination in question is not subject to dismissal based on medical necessity.

3. The designated doctor is required to bill an examination to determine maximum medical improvement with CPT code 99456 and modifier “W5.”[3] The submitted documentation supports that Dr. Winter performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[4]

   The designated doctor is required to bill an examination to determine the impairment rating of an injury with CPT code 99456 and modifier “W5.”[5] Review of the submitted documentation finds that Dr. Winter performed an impairment rating evaluation of the vision. The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.[6]

   The total allowable reimbursement for the examination in question is $500.00. The insurance carrier paid $350.00. An additional reimbursement of $150.00 is recommended.

[1] 28 TAC §133.307(d)(1)
[2] TLC §408.0041 (h)
[3] 28 TAC §§134.250(3)(C) and 134.240(1)(B)
[4] 28 TAC §134.250(3)(C)
[5] 28 TAC §§134.250(4)(A) and 134.240(1)(A)
[6] 28 TAC §134.250(4)(D)(v)

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered. For the reasons stated above, the Texas Department of Insurance, Division of Workers' Compensation (DWC) finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

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 $150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July 20, 2021
Signature	Medical Fee Dispute Resolution Officer	Date

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.