

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

John P. Obermiller, M.D.

**Respondent Name**

Indemnity Insurance Co. of North America

**MFDR Tracking Number**

M4-21-2181-01

**Carrier's Austin Representative**

Box Number 15

**DWC Date Received**

July 28, 2021

### Summary of Findings

| Dates of Service | Disputed Services  | Amount in Dispute | Amount Due |
|------------------|--|-------------------|------------|
| October 13, 2020 | Required Medical Examination – Multiple Impairments (99456-MI) | \$50.00           | \$0.00     |

### Requestor's Position

A Post-DD RME was performed on October 13, 2020 by John P Obermiller MD ... Per the DWC022, Dr. Mead was asked to address **Maximum Medical Improvement and Impairment Rating and Extent of compensable injury.**

**Amount in Dispute:** \$50.00

### Respondent's Position

“Genex Bill Review has carefully audited the original review and determined the original review under bill number F7TX 98994 is correct. CPT 99456-MI (line 3) denied indicating modifier is missing. This is a billing for an MMI rating, which also requires modifier W5.”

**Response Submitted by:** ESIS

## Findings and Decision

### Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

### Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
- 18 – Exact duplicate claim/service.

### Issues

1. Is John P. Obermiller, M.D. entitled to additional reimbursement?

### Findings

1. Dr. Obermiller is seeking reimbursement for the calculation of an additional impairment rating given as part of an examination performed at the request of the insurance carrier. 28 TAC §180.22 (h) reserves reimbursement for multiple impairment ratings performed as part of a **designated doctor** examination.

The evidence presented with the dispute request does not support that this service was provided as part of a designated doctor examination. Therefore, no reimbursement can be recommended.

### Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

### Authorized Signature

|           |  |                    |
|-----------|--|--------------------|
| _____     | _____                                  | September 21, 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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).