



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Jan Petrasek, M.D.

**Respondent Name**

WCF National Insurance Company

**MFDR Tracking Number**

M4-21-2271-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

August 11, 2021

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 16, 2021	Designated Doctor Examination (99456-W5-WP)	\$150.00	\$150.00

### Requestor's Position

"DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION ... THE CORRECT MODIFIERS ARE W5 WP NOT W5 NP AS LISTED ON THE EOB."

**Amount in Dispute:** \$150.00

### Respondent's Position

"Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed."

**Response Submitted by:** Gallagher Bassett

## 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:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 4250 – An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance
- 00563/193 – Original payment is being maintained. Upon review, it was determined that this claim was processed properly.
- 00950 – This bill is a reconsideration of a previously reviewed bill. Allowance amounts reflect any changes to the previous payment.

### Issues

1. Is Jan Petrasek, M.D. entitled to additional reimbursement?

### Findings

1. Dr. Petrasek is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating.

According to 28 TAC §§134.250 (3)(C) and 134.240 (1)(B), the examining doctor is required to bill an examination to determine maximum medical improvement with CPT code 99456 and modifier "W5." The submitted documentation supports that Dr. Petrasek performed an evaluation of maximum medical improvement as ordered by DWC. 28 TAC §134.250 (3)(C) states that the maximum allowable reimbursement (MAR) for this examination is \$350.00.

When the examining doctor calculates an impairment rating, 28 TAC §§134.250 (4)(A) and 134.240 (1)(A) require the doctor to bill with CPT code 99456 and modifier "W5." Review of the submitted documentation finds that Dr. Petrasek performed impairment rating evaluations of a hernia.

The rule at 28 TAC §134.250 (4)(D) defines the fees for the calculation of an impairment

rating for non-musculoskeletal body areas. The MAR for the assignment of impairment rating for non-musculoskeletal body areas is \$150.00 each.

The total reimbursement for the examination in question is \$500.00. The insurance carrier paid \$350.00. An additional reimbursement of \$150.00 is 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 established that additional reimbursement of \$150.00 is due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that WCF National Insurance Company must remit to Jan Petrasek, M.D. \$150.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### **Authorized Signature**

_____	_____	November 3, 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).

