TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Donald Gwartney, D.C.

Respondent Name
City of Houston

MFDR Tracking Number
M4-23-3341-01

Carrier's Austin Representative
Box Number 29

DWC Date Received
August 30, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 9, 2023	Designated Doctor Examination 99456-W5-WP	$0.00	$0.00
	Designated Doctor Examination 99456-W8-RE	$0.00	$0.00
	Return to Work Form 99080-73	$45.00	$0.00
	Total	45.00	$0.00

Requestor's Position

"DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION"

Amount in Dispute: $45.00

Respondent's Position

"Based on a review of the submitted documentation a recommendation is not required. The request is payment of 99080-73 x 3 for work status reports. Per 134.204 reports are considered inclusive of the MMI/IR MAR."

Response Submitted by: IMO Managed Care

Findings and Decision

Authority

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

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 TAC §134.235 sets out the fee guidelines for examinations to determine the ability to return to work.

3. 28 TAC §134.239 sets out the guidelines regarding work status forms for examinations to determine the ability to return to work.

Denial Reasons

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

- 236 – This procedure or procedure/modifier combination is not compensable with another procedure or procedure/modifier combination provided on the same day accordiong to the NCCI edits or work comp state regs/fee schedule requirements.
- 411 – National Correct Coding Initiative edit – either mutually exclusive of or integral to another service performed on the same day.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- W3 – TDI Level 1 Appeal means a request for reconsideration under 133.250 of this title or an appeal of an adverse determination under Chapter 19, Subchapter U of this title.

Issues

1. What are the services considered in this dispute?

2. Is Donald Gwartney, D.C. entitled to additional reimbursement?

Findings

1. Dr. Gwartney submitted a dispute request for a designated doctor examination that included evaluations for maximum medical improvement, impairment rating, and ability to return to work. Dr. Gwartney is seeking $0.00 for these services. Therefore, these services will not be considered in this dispute.

   He is seeking reimbursement of $45.00 for three Texas Workers' Compensation Work Status

Reports (DWC073). This service is considered in this dispute.

2. Rule 28 TAC §134.235 states, in relevant part, "When conducting a division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier 'RE.' In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title and shall include division-required reports."

   28 TAC §134.239 states, "When billing for a work status report that is not conducted as a part of the examinations outlined in §134.240 and §134.250 of this title, refer to §129.5 of this title."

   Because the DWC073 forms were completed as part of an examination outlined in 28 TAC §134.240, reimbursement for the form is included in reimbursement for the examination. Per explanation of benefits dated July 11, 2023, the insurance carrier paid $500.00 for the examination to determine the ability to return to work. No additional 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 requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November 21, 2023
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. 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 three or email 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 tres o correo electronico CompConnection@tdi.texas.gov.