Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
R. David Bauer, MD

Respondent Name
Accident Fund Insurance Company of America

MFDR Tracking Number
M4-12-2816-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
May 3, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…CARRIER IS REQUIREDD TO PAY RME'S…THE CURRENT RULES ALLOW REIMBURSEMENT…"

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "**The Carrier has paid these bills, and so requests dismissal of the dispute.**"

Response Submitted by: Stone Loughlin & Swanson, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 19, 2011	Required Medical Examination (RTW)	$300.00	$300.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for billing and reimbursing Division-specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 18 – Duplicate claim/service
   - 247 – A payment or denial has already been recommended for this service.
   - D1 – Duplicate Control Number 15884
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Are the disputed services duplicates to paid services?
2. What is the correct MAR for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied the services in dispute as a "duplicate claim/service." In their position statement, they state that the services in dispute have already been paid and provide "screen shots" as evidence. However, the screen shots provided do not indicate what services (by CPT Code or description) are being paid, or what the reduction reasons were. They indicated the billed amount for the paid services was $745.00, with a payment of $527.90. Review of the submitted documentation finds that the billed amount for the disputed services is $700.00. Therefore, the insurance carrier's denial is not supported by the submitted documentation.
2. Per 28 Texas Administrative Code §134.204 (k), "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. 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 MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee." The submitted documentation indicates that the requestor performed a required medical evaluation to determine the injured employee's ability to return to work. Therefore, the correct MAR for this examination is $500.00.
3. The total allowable for the disputed services is $500.00. Review of the submitted documentation finds that the insurance carrier has paid $0.00. The requestor is seeking $300.00. Therefore, a reimbursement of $300.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	April 23, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.