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 and Address

G. KENNETH DRIGGS, MD
10109 MCKALLA PLACE, STE E
AUSTIN, TX 78758

Respondent Name
KIEWIT CORP

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-12-3099-01

MFDR Date Received

JUNE 12, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was denied in error. This claim was for a Division ordered Designated Doctor Re-Exam. We billed a total of $2,350.00 for this claim but were paid only $850.00. The explanation given on the EOB justifying the denial states: *PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE,* however, this is incorrect. The reduction of parts of this claim is in violation of the rules of the Texas Department of Insurance Division of Workers' Compensation as this service was ordered on the DWC-32."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Texas Labor Code requires reimbursement for all medical expenses to be fair and reasonable and be designed to ensure the quality of medical care and to achieve effective medical cost control. TEX. LABOR CODE Section 413.011 (d). The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 15, 2012	CPT Code 99456-W5-WP	$300.00	$0.00

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 amended to be effective May 31, 2012, *37 Texas Register 3833*,applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 10, 2012

   - 150 – Payer deems the information submitted does not support this level of service

   Explanation of benefits dated April 25, 2012

   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration. Request for reconsideration reviewed. No further payment recommended

Issues

1. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. Requestor billed with CPT Code 99456-W5-WP with one unit in the amount of $950.00, 99456-W5-WP one unit in the amount of $800.00 and 99456-W8-RE one unit in the amount of $600.00 for an examination of a Medical Maximum Improvement (MMI) and Impairment Rating (IR) and Return to Work (RTW). CPT Code 99456-W5-WP and 99456-W8-RE is not in dispute.

   Review of the submitted documentation finds DWC-32 / Request for Designated Doctor Examination was requested to address Maximum Medical Improvement (MMI), Impairment Rating (IR) and Return to Work (RTW) only. Findings of the Report of Medical Evaluation documents that Maximum Medical Improvement (MMI) and Return to Work (RTW) was only addressed.

   Therefore, CPT Code 99456-W5-WP is not supported.

2. The respondent issued payment in the amount of $0.00 for CPT Code 99456-W5-WP. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that no additional reimbursement is due.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	5/6/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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