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
THOMAS DILGER MD

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-13-1101-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
January 03, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is a Designated Doctor Exam performed on 5/7/12. Despite multiple attempts the insurance carrier is attempting theft of services rendered. The DDE & claim were faxed to the carrier on 5/11/12. Therefore, MDR is filed via certified mail with receipt."

Amount in Dispute: $1,150.00 + interest

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We base our payments on the Texas Fee guidelines and the Texas Department of Insurance, Division of Workers' Compensation Acts and Rules. The documentation submitted by the provider has been reviewed and payment in the amount of $1,150.00 has been issued to provider. Provider should received check in the next 5-7 business days. EOB will be sent as soon as available."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 07, 2012	CPT Code 99456-RE-W8 and CPT Code 99456-WP-W5	$1,150.00 + interest	$22.99

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 §134.130 sets outs the procedures for Interest for Late Payment on Medical Bills and Refunds.
2. 28 Texas Administrative Code §133.240 sets out the procedures for Medical Payments and Denials.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.204 sets out the fee guideline for workers' compensation specific services.
5. Texas Labor Code §413.019 sets out the procedures for Interest Earned for Delayed Payments, Refund, Or Overpayment.
6. Texas Labor Code §401.023 sets out the procedures for Interest or Discount Rate.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

- ZC72 – In the event his payment needs to be returned to the payer, please return the check to PO Box 8011, Wausua WI 54402. To submit a dispute or appeal, please see the address in the upper left hand corner of this EOB

Issues

1. What is the maximum allowable reimbursement for the disputed service?
2. Is the requestor entitled to interest for the disputed service?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204(j)(3)(C) states "An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." In order for the requestor to be reimbursed in accordance with 28 Texas Administrative Code §134.204(j)(3)(C), the requestor was required to perform a maximum medical improvement examination. Review of submitted documentation provided by the requestor finds the requestor performed a maximum medical improvement examination for disputed service May 07, 2012. The maxim allowable reimbursement for maximum medical improvement is $350.00

   Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II) states "If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area." In order for the requestor to be reimbursed in accordance with 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(-a-), the requestor was required to perform a impairment rating evaluation with full physical evaluation to the upper extremity. Review of the submitted documentation provided by the requestor finds a full physical evaluation for impairment rating with one body area rated using range of motion. The reimbursement for impairment rating with one body area is $300.00

   Per 28 Texas Administrative Code §134.204(k) states "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."

   In order for the requestor to be reimbursed in accordance with 28 Texas Administrative Code §134.204(k), the requestor was required to perform a return to work examination. Review of submitted documentation finds the requestor performed a return to work examination to the injured employee for disputed service May 07, 2012.

   The maximum allowable reimbursement is $500.00.

   The total maximum reimbursement for maximum medical improvement, impairment rating and return to work examinations performed for disputed service May 07, 2012 is $1,150.00.

   The insurance carrier provided explanation of benefits with audit date January 24, 2013 indicating payment allowed in the amount of $1,150.00 for maximum medical improvement, impairment rating and return to work examination.

   Therefore, the requestor is not entitled to additional payment.
2. Per 28 Texas Administrative Code §134.130 the amount of $22.99 for interest is owed.
3. The division concludes that the total allowable for interest is $22.99. The respondent issued payment in the amount of $0.00 for interest. Based upon the documentation submitted, additional reimbursement in the amount of $22.99 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 $22.99.

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 $22.99 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/26/14 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.