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

SPORTS THERAPY CENTER
2225 WILLIAMS TRACE BLVD STE 104
SUGAR LAND TX 77478

Respondent Name

HARTFORD INSURANCE COMPANY OF

MFDR Tracking Number

M4-13-1968-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The enclosed claim was reduced in error. This claim was for a Division ordered Designated Doctor Exam. We billed a total of $2,950.00 for this claim but were paid $937.50."

Amount in Dispute: $12.50

RESPONDENT'S POSITION SUMMARY

Respondent's Summary: Carrier acknowledged DWC-60 on April 12, 2013. No response submitted.

Response Submitted by: Burns Anderson Jury Brenner & Donovan.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 11, 2012	CPT Code 99456 WP W5	$12.50	$12.50

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 a medical fee dispute.
2. 28 Texas Administrative Code§134.204 sets out the fee guideline for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits

   - W1- Workers compensation state fee schedule adjustment.
   - QA- The amount adjusted is due to bundling or unbundling of services.
   - B13- Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - PI-There are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary. The amount adjusted is generally not the patients responsibility, unless the workers compensation state law allows the patient to be billed.

Issues

1. Did the insurance carrier pay the correct reimbursement amount to the provider?
2. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied disputed services with reason code QA- “The amount adjusted is due to bundling or unbundling of services.”
    - Per 28 Texas Administrative Code §134.204 (3)(C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350.
    - Per 28 Texas Administrative Code §134.204 94) (C) (iii)If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier "WP." Reimbursement shall be 100 percent of the total MAR.

    Review of the documentation found that the requestor billed for CPT code 99456 WP W5 for date of service 9/11/12.
2. The respondent issued payment in the amount of $87.50. Per 28 Texas Administrative Code §134.204 (3)(C) the recommended allowance is $350.00. The amount in dispute by the requestor is $12.50, therefore $12.50 is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due.

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 $12.50 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		March , 2014
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 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.