



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Larry W. Leininger, M.D.

Respondent Name

OBI National Insurance Company

MFDR Tracking Number

M4-17-0844-01

Carrier's Austin Representative

Box Number 29

MFDR Date Received

November 28, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION/PARTIAL PAY"

Amount in Dispute: \$250.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: December 3, 2015, Designated Doctor Examination, \$250.00, \$250.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 division-specific services from March 1, 2008 until September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- P1
- P12 - Workers' compensation jurisdictional fee schedule adjus
- Z710 - The charge for this procedure exceeds the fee schedule allowance.

Issues

- 1. What are the services in dispute?
- 2. Is Larry W. Leininger, M.D. entitled to additional reimbursement?

Findings

- 1. Dr. Leininger is seeking an additional reimbursement for a designated doctor examination performed on date of service December 3, 2015. Dr. Leininger is seeking \$0.00 for procedure code 99456-W5-NM, so this code will not be considered in this dispute. Dr. Leininger is seeking \$250.00 for procedure code 99456-W6-RE. This is the service considered for this dispute.
- 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** [emphasis added], 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 Designated Doctor performed an examination to determine the extent of the compensable injury. Therefore, the maximum allowable reimbursement for this examination is \$500.00. OBI National Insurance Company reimbursed \$250.00. An additional reimbursement of \$250.00 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 \$250.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$250.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	March 17, 2017 Date
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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, 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 MFDR 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.