



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Daniel Schere, M.D.

Respondent Name

AIU Insurance Co.

MFDR Tracking Number

M4-24-1209-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

January 30, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 17, 2023	Evaluation of Medical Care 99456-RE	\$850.00	\$0.00

Requestor's Position

Initial Position Statement: "CERTIFYING DOCTOR EXAMINATION NO PAYMENT RECEIVED"

Subsequent Position Statement dated March 29, 2024: "We have received a partial payment. Please assign this for decision."

Amount in Dispute: \$850.00

Respondent's Position

"The Carrier has reviewed the documentation and determined the Provider is entitled to reimbursement. Reimbursement for these services is being issued in accordance with the Texas Workers' Compensation Act and adopted Rules of the Division of Workers' Compensation."

Response Submitted by: Constitution State Services

Findings and Decision

Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.235](#) sets out the fee guidelines for examinations for the evaluation of medical care.

Denial Reasons

The insurance carrier reduced or denied the payment for the disputed services with the following claim adjustment codes:

- 29 – The time limit for filing has expired.
- 4271 – Per Tx Labor Code Sec. 408.027, providers must submit bills to payors within 95 days of the date of service.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 863 – Reimbursement is based on the applicable reimbursement fee schedule.
- 9105 – Additional payment made based on State Decision. Payment is final.
- 2008 – Additional payment made on appeal/reconsideration.

Issues

1. Is Daniel Schere, M.D. entitled to additional reimbursement?

Findings

1. Dr. Schere submitted this dispute in accordance with 28 TAC §133.307 seeking reimbursement of \$850.00 for an examination and the evaluation of medical care. In its position statement, the insurance carrier does not maintain its denial of payment for the services in question.

28 TAC §134.235 states, in pertinent part, "The following shall apply to return to work (RTW)/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 maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be \$500 in accordance with §134.240 of this title and shall include division-required reports."

DWC finds that the total reimbursement allowable for the services in question is \$500.00. Per explanation of benefits dated February 12, 2024, the insurance carrier paid this amount. No additional reimbursement is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

May 7, 2024

Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option three or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in [28 TAC §141.1 \(d\)](#).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción tres o correo electrónico CompConnection@tdi.texas.gov.