



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Patricia Cates, D.C.

Respondent Name

Hanover Casualty Co.

MFDR Tracking Number

M4-24-1446-01

Carrier's Austin Representative

Box Number 47

DWC Date Received

March 6, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 24, 2023	Designated Doctor Examination 99456-W5-26 and 99456-W5-TC	\$1,090.00	\$100.00
Total		\$1,090.00	\$100.00

Requestor's Position

"We seek full reimbursement for the outstanding balance of \$290.00 along with interest accrued..."

Amount in Dispute: \$1,090.00

Respondent's Position

"After careful review of the submitted documentation from the provider it was determined that an additional allowance is owed. The bill has been reprocessed for payment. The submitted bill was reviewed and payment has been recommended in the amount of an additional \$190.00 for code 99456-W5-TC for a total allowance of \$700.00. At this time it appears the dispute has been resolved by way of the bill review that was processed on 3/20/2023 on Bill ID ... in the amount of \$190.00 for CPT Code 99456-W5-TC."

Response Submitted by: Metadata

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 §134.250](#) sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

Denial Reasons

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

- 01 (P12) – The charge for the procedure exceeds the amount indicated in the fee schedule.
- W3 – No additional reimbursement allowed after review of appeal/reconsideration.
- YO (P12) – Denial after Reconsideration.

Issues

1. Have the services in dispute received additional reimbursement after the request for this medical fee dispute resolution (MFDR) was received by DWC?
2. Is the requestor entitled to additional reimbursement?

Findings

1. A review of the documentation submitted and information known to DWC, finds that additional reimbursement for the service in dispute was allowed on March 20, 2024, in the amount of \$190.00. The request for MFDR was received on March 6, 2024. As of the date of this review, DWC finds that the total amount of reimbursement that has been allowed for the services in dispute is \$700.00.
2. The requestor, Dr. Patricia Cates, is seeking additional reimbursement for a designated doctor examination that includes the services of an examination to determine maximum medical improvement (MMI) and impairment rating (IR).

The submitted documentation supports that Dr. Cates performed an evaluation of maximum medical improvement as ordered by DWC. In accordance with 28 TAC §134.250 (3)(C), the

maximum allowable reimbursement (MAR) for this examination is \$350.00.

Review of the submitted documentation finds that Dr. Cates performed an impairment rating evaluation of the left upper extremity and the spine with range of motion testing. The rule at 28 TAC §134.250 (4)(C)(ii) defines the fees for the calculation of an impairment rating for musculoskeletal body areas. The MAR for the evaluation of the first musculoskeletal body area performed with range of motion is \$300.00. The MAR for the evaluation of subsequent musculoskeletal body areas is \$150.00 each. The requestor assigned an impairment rating utilizing range of motion for the upper extremity and the spine, two musculoskeletal body areas.

In accordance with 28 TAC §134.250, the reimbursements which apply to the disputed examination rendered on October 24, 2023, are:

- For an MMI examination reimbursement is \$350.00.
- For IR examination of two musculoskeletal body areas with range of motion, reimbursement is \$450.00.
- The total MAR amount for this disputed designated doctor service is \$800.00.
- The insurance carrier paid a total amount of \$700.00 for the disputed date of service.
- Additional reimbursement in the amount of \$100.00 is recommended.

DWC finds that the requestor, Dr. Cates, is entitled to additional reimbursement in the amount of \$100.00 for the disputed designated doctor examination rendered on October 24, 2023.

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 established that additional reimbursement in the amount of \$100.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that Hanover Casualty Co. must remit to Patricia Cates, D.C. \$100.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

May 16, 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.