



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

William Meiser, D.O.

Respondent Name

State of Texas

MFDR Tracking Number

M4-24-2251-01

Carrier's Austin Representative

Box Number 45

DWC Date Received

June 23, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 3, 2022	Designated Doctor Examination 99456-W5-WP	\$650.00	\$0.00

Requestor's Position

"THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: \$650.00

Respondent's Position

"The Office reviewed the billing submitted by Pacific Billing Services and determined that the diagnosis code(s) being evaluated as indicated in data fields 21 A & B of this exam does not coincide with the report. The Office responded with a comment to Pacific Billing to confirm that the diagnosis in Box A & B matches the evaluation report. The Office has not received a medical bill with a correction to the diagnosis' as of the date of this response."

Response Submitted by: State Office of Risk Management

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 \(TAC\) §133.10, effective April 1, 2014, 38 TexReg 9594](#), sets out the procedures for complete medical bills on dates of service prior to June 1, 2024.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.

Denial Reasons

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

- 16 – Claim/service lacks information which is needed for adjudication. Remark codes whenever appropriate.
- 251 – The attachment content received did not contain the content required to process this claim or service
- Notes: "Bill DX and/or documentation does not support services are being rendered for the compensable injury. Please resubmit with DX code(s) that are related to W/C compensable injury."
- 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
- Notes: "INJURY NOTES AND MEDICAL RECORDS SHOW (redacted). EOB STATES THE (redacted)."
- 18 – Exact duplicate claim/service
- Notes: "DX 1 is pointing evaluation to the (redacted). The (redacted) is not the reported (redacted). Please confirm DX 1 matches what your evaluating and is the reported (redacted)."

Issues

1. Is State Office of Risk Management's reason for denial of supported?

Findings

1. William Meiser, D.O. is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating. The insurance carrier denied payment citing inconsistency between the billing diagnoses codes and documented diagnosis.

28 TAC §133.10(f)(1)(M) requires "at least one diagnosis code and the applicable ICD indicator" for the "diagnosis or nature of injury."

Review of the submitted narrative report indicates that the examination was for an injury to the (redacted). However, billing documents and the Report of Medical Evaluation (DWC069) indicate that the examination was solely for an injury to the (redacted).

DWC finds that the insurance carrier's denial of payment is supported. No reimbursement can be 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 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

July 11, 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.