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
G PETER FOOX MD

Respondent Name
FIDELITY & GUARANTY INSURANCE

MFDR Tracking Number
M4-11-3185-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 19, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from Table of Disputed Services: "To Pay Per TX Fee Schedule IR=350.00 V5-144.80 total =494.80"

Amount in Dispute: $133.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has paid the disputed billing to the requestor. On 4/15/11, the requestor was reimbursed $364.80 for the requested services. Please dismiss."

Response Submitted by: Xchanging

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 01, 2011	CPT Code 99455V5-WP Maximum Medical Improvement and Impairment Rating Examination	$133.60	$0.00

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 medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the medical fee guidelines for workers' compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME

Issues

1. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.204 (j)(3) states "The following applies for billing and reimbursement of an MMI evaluation. (A) An examining doctor who is the treating doctor shall bill using CPT Code 99455 with the appropriate modifier. (i) Reimbursement shall be the applicable established patient office visit level associated with the examination. (ii) Modifiers "V1", "V2", "V3", "V4", or "V5" shall be added to the CPT code to correspond with the last digit of the applicable office visit."

   The reimbursement for Maximum Medical Improvement Examination that was performed on the disputed service April 01, 2011 is $214.79.

   28 Texas Administrative Code §134.204 (j)(4)(C)(ii)(I) states "$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used."

   The reimbursement for Impairment rating examination performed on disputed service April 01, 2011 is $150.00 for one body area performed (Spine) using diagnosis related estimate (DRE) method.

   Therefore, the total MAR for both examinations of Maximum Medical Improvement and Impairment Rating performed by the treating doctor with one body area rated the amount is $364.79.

   The carrier paid a total amount of $364.80. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		9/12/14
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.