**Texas Department of Insurance, Division of Workers' Compensation**
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

| | |
|---|---|
| Requestor's Name and Address:<br><br>Daniel Thompson III, MD<br>112 Powhatan Cir.<br>Sewanee, TN 37375 | MFDR Tracking #: M4-07-3730-01<br>DWC Claim #:<br>Injured Employee: |
| Respondent Name and Box #:<br><br>Fidelity & Guaranty Insurance<br>Box # 19 | Date of Injury:<br>Employer Name: Clayton Homes Inc.<br>Insurance Carrier #: 900061186 |

## PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary:
"DD examination ordered and scheduled by DWC."
Principle Documentation:

1. DWC 60 package
2. CMS 1500(s)
3. EOB(s)

## PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary:
"The carrier's position remains the same."
Principle Documentation:

1. Response to DWC 60

## PART IV: SUMMARY OF FINDINGS

| Date(s) of Service | Denial Code(s) | CPT Code(s) and Calculations | Part V Reference | Amount Due |
|---|---|---|---|---|
| 9-27-06 | W1, 147, 165, 18 | 99456-NM | 1-5 | $350.00 |
| **Total Due:** | | | | |

## PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Section §413.011(a-d) titled, *Reimbursement Policies and Guidelines*, and Division Rule 134.202 titled, *Medical Fee Guideline* effective August 1, 2003, sets out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "W1 – Workers comp state fee schedule adjustment $0.00; 147-Provider contracted/negotiated rate expired or not on file; 165 – Payment denied /reduced for absence of, or exceeded referral; and 18 – Duplicate claim/service."

2. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment.

3. According to Rule 134.202(e)(6)(C)(iii), "An examining doctor, other than the treating doctor, shall bill using the 'Work related or medical disability examination by other than the treating physician….' CPT code. Reimbursement shall be $350."

4. According to Rule 134.202(e)(6)(B)(i), "If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with subparagraph (C). Modifier 'NM' shall be added."

5. On this date, the Requestor billed $350.00 for 99456-NM. Per Rule 134.202(e)(6)(C)(iii), the Requestor is entitled to reimbursement of $350.00 for MMI evaluation. The insurance carrier paid $0.00. The Requestor is entitled to the difference between amount paid and due, which equals $350.00.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code Sec. §413.011(a-d)
28 Texas Administrative Code Sec. §134.1, §134.202

**PART VII: DIVISION DECISION AND/OR ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $350.00 plus accrued interest, due within 30 days of receipt of this Order.

**ORDER:**

| | Elizabeth Pickle, RHIA | June 15, 2007 |
|---|---|---|
| Authorized Signature | Medical Fee Dispute Resolution Officer | Date |

**PART VIII: YOUR RIGHT TO REQUEST JUDICIAL REVIEW**

Appeals of medical dispute resolution decisions and orders are procedurally made directly to a district court in Travis County [see Texas Labor Code, Sec. §413.031(k), as amended and effective Sept. 1, 2005]. An appeal to District Court must be filed not later than 30 days after the date on which the decision, that is the subject of the appeal, is final and appealable. The Division is not considered a party to the appeal.

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