



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

Paula Springer, MD

Respondent Name

Hartford Fire Insurance Company

MFDR Tracking Number

M4-13-3385-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

August 22, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This request was made in the form and manner prescribed by the Division. The report of the designated doctor is given presumptive weight regarding the issue(s) in question and/or dispute. The designated examination was requested to resolve question(s) about the following:

**Impairment caused by the employee's compensable injury
Attainment of maximum medical improvement**

In this case the reimbursement is not according to the Rule. The Designated Doctor may conduct two distinct exams in the same day. He shall be reimbursed \$350.00 per exam. The procedural guidance for bundling of codes does not apply to Designated Doctors exams. The examination for MMI/IR is reimbursed at \$350.00 and \$150.00 for one body area (DRE) method. When a permanent impairment exists, A Division of Workers' Compensation (DWC) certified impairment rating (IR) doctor must perform a physical examination to determine maximum medical improvement (MMI) and assign an IR. When the MMI and the range of motion, strength, or sensory testing required assigning an IR for the musculoskeletal body area(s), the doctor should bill using component modifier – WP, The Maximum allowable is reimbursed at 100%.

**Determine maximum medical improvement & impairment rating
Exam \$350.00 + Body Area \$150.00 DRE Method
(Reimbursement \$500.00)**

...**We seek full reimbursement for the outstanding balance of \$150.00** along with interest accrued according to Rule 134.803 Calculating Interest for Late Payments on Medical Bills."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please be advised that this claim was denied by The Hartford for no coverage. The Hartford is not the carrier of record for this company.

Enclosed please find a copy of the PLN 1 dated 11/29/12 denying the claim in its entirety."

Response Submitted by: The Hartford, PO Box 26300, Austin, TX 78755-0300

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 22, 2013	Designated Doctor's Exam to Determine Impairment Rating	\$150.00	\$150.00

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 (j)(4) defines the fee schedule for determining impairment rating of musculoskeletal body areas.
3. 28 Texas Administrative Code §130.1 (c) defines what constitutes an impairment rating and when it should be assessed.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - W1 – Workers Compensation State Fee Schedule Adjustment
 - 309 – The charge for this procedure exceeds the fee schedule allowance
 - 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204 (j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed.
 - W4 – No additional reimbursement allowed after review of appeal/reconsideration/request for second review

Issues

1. Has the insurance carrier waived its right to address liability for this billed claim?
2. What is the correct MAR for an examination to determine Impairment Rating?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.307 (d)(2)(F) states, "**The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was file with the division and the other party.** Any new denial reasons or defenses raised **shall not be considered in the review**" [emphasis added]. A review of the submitted documentation finds that Sedgwick Claims Management Services, Inc. acting on behalf of The Hartford for this claim, failed to address liability as a reason for denial on the explanations of benefits. Therefore, The Hartford has waived its right to address liability for this billed claim.
2. Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas. (ii) The MAR for musculoskeletal body areas shall be as follows. (I) **\$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used**" [emphasis added]. The narrative report from the designated doctor indicates that the impairment rating for the lumbosacral spine was "found on Table 72, DRE Category I, page 110...based on the *Guides to the Evaluation of Permanent Impairment*, Fourth Edition, by the American Medical Association," with no range of motion performed. Therefore, the correct MAR for the examination to determine Impairment Rating is \$150.00.
3. Per 28 Texas Administrative Code §130.1 (c), "Assignment of Impairment Rating. (1) An impairment rating is the percentage of permanent impairment of the whole body resulting from the current compensable injury. **A zero percent impairment may be a valid rating.** (2) **A doctor who certifies that an injured employee has reached MMI shall assign an impairment rating** for the current compensable injury using the rating criteria contained in the appropriate edition of the AMA Guides to the Evaluation of Permanent Impairment, published by the American Medical Association (AMA Guides)" [emphasis added]. Because the Designated Doctor determined that the injured employee had reached Maximum Medical Improvement, the doctor had an obligation to do an examination to determine Impairment Rating. Therefore, the requestor is entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

December 29, 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request 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 §141.1(d).

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