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
Victor Arellano, MD

Respondent Name
Service Lloyds Insurance Company

MFDR Tracking Number
M4-14-3374-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
July 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to TAC Rule 134.204 (J) (i) (ii) all body parts that are examined are to be reimbursed at 100%. Along with this letter, I am attaching the EOB,CMS-1500 form, page 3 of the injured workers DWC32 showing the body parts that were asked to be addressed, the report from the designated doctors examination, and the fee schedule from TDI … I am asking if you could kindly reconsider this claim for payment."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "IR was completed based on ROM testing of the knee. … MMI & IR reimbursement for 1 body part was allowed … Additionally, the request for reconsideration was in excess of 10 months beyond the DOS so it was considered untimely filed."

Response Submitted by: Corvel Corporation, 15301 Dallas Pkwy #300, Addison, TX 75001

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 17, 2013	Impairment Rating of 2 Musculoskeletal Body Areas	$300.00	$ 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 §130.1 (c) pertains to assignment of impairment ratings and the documentation required of the examining doctor.
3. 28 Texas Administrative Code §134.204 (j) (4) (C) defines the MAR for assignment of an impairment rating by a doctor other than the treating doctor.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   From Explanation of Benefits dated 08/05/2013:
   - 150 – Payment adjusted/unsupported service level
   - 16 – Not All Info Needed for Adjudication was Supplied

From Explanation of Benefits dated 06/05/2014:

- 150 – Payment adjusted/unsupported service level
- 29 – Time Limit for Filing Claim/Bill has Expired

Issues

1. Did the requestor provide the required documentation for determining impairment ratings for 3 musculoskeletal body areas according to §130.1 (c)(3)?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier submitted a Request for Designated Doctor Examination (DWC032) to address Maximum Medical Improvement and Impairment Rating including spine and torso, upper extremities, and lower extremities.

   28 Texas Administrative Code §130.1 (c)(3) states: "…The doctor assigning the impairment rating shall: (A) identify objective clinical or laboratory findings of permanent impairment for the current compensable injury; (B) document specific laboratory or clinical findings of an impairment; (C) analyze specific clinical and laboratory findings of an impairment; (D) compare the results of the analysis with the impairment criteria and provide the following: (i) **A description and explanation of specific clinical findings related to each impairment, including zero percent (0%) impairment ratings;** and (ii) A description of how the findings relate to and compare with the criteria described in the applicable chapter of the AMA Guides. The doctor's inability to obtain required measurements must be explained." [emphasis added] The report from the designated doctor only provides information for the knee in accordance with the stated rule.
2. 28 Texas Administrative Code §134.204 (j) (4) (C) states, "(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. (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body area." [emphasis added] The requestor billed 99456 W5 WP with two (2) units for impairment rating for two (2) areas, however the submitted documentation only supports impairment rating of the knee. The insurance carrier paid reimbursement of $300.00 for one (1) musculoskeletal body area with range of motion. Therefore, the requestor is not entitled to additional reimbursement.

   While all evidence presented may not have been discussed, it was considered.

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

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	December , 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.