



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

ROLLIN THRIFT MD

Respondent Name

TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number

M4-14-3446-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

July 21, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We requested a reconsideration from the insurance, Texas Mutual Insurance, for a claim on patient, [injured worker], for date of service 05/23/2014 in the amount of \$650.00 for a Designated Doctor Exam. We did received payment for \$500.00. We submitted a reconsideration request on 06/23/2014, for the balance of \$150.00."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 5/23/14. The requestor used the DRE method to assign an impairment rating into category 3. Texas Mutual paid the requestor \$150.00 for this. No additional payment is due."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 23, 2014	Impairment Rating Evaluation of a Musculoskeletal Body Area	\$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 sets out fee guidelines for Worker's Compensation specific services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - CAC-W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL
 - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY

- 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
- CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 790 – THIS CHARGE WAS REIMBURSED IN ACCORDANCE TO THE TEXAS MEDICALF EE GUIDELINE

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the total allowable amount for the impairment rating of the spine?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute involves a Designated Doctor Impairment Rating (IR) evaluation of the spine, with reimbursement subject to the provisions of 28 Texas Administrative Code §134.204(j)(4)(C)(ii), which states that “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.”
2. According to the explanation of benefits and the respondent’s position statement, the total of \$150 was reimbursed by the carrier for the IR of the spine. The requestor disagrees. In its position, the requestor argues that the carrier should have allowed a total of \$300 for the impairment rating of the spine because it asked for reimbursement based upon §134.204(j)(4)(C)(ii) **(II)(-a-) [emphasis added]**. In order for the requestor to be reimbursed pursuant to rule §134.204(j)(4)(C)(ii)(II)(-a-), the health care provider, in this case, was required to perform a full physical evaluation with range of motion of the spine. Review of the submitted documentation finds that a full physical evaluation and range of motion were performed on the spine. The provider documents: “Based on Page 99 from the AMA Guides to the Evaluation of Permanent Impairment, 4th edition, the Range of Motion Differentiator was utilized in determining placement of the examinee in to the correct DRE Category. Per the Guides, “the physician or examiner may use certain clinical procedures or determinations in placing the patient’s impairment in the proper category”. ... As you can see from the documentation in the report, Range of Motion was performed and utilized for this evaluation.” The Division concludes that the impairment rating of the spine is allowed at \$300 in accordance with the requirements of §134.204(j)(4)(C)(ii)(II)(-a-).
3. The division concludes that the total allowable for the impairment rating of the spine is \$300. The respondent issued payment in the amount of \$150 for the IR of the spine. Based upon the documentation submitted, additional reimbursement in the amount of \$150 is recommended.

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

Medical Fee Dispute Resolution Officer

12/30/14

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.