



**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](http://www.tdi.texas.gov)

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**GENERAL INFORMATION**

**Requestor Name**

Lawrence W. Parks, DC

**Respondent Name**

Netherlands Insurance Company

**MFDR Tracking Number**

M4-15-0664-01

**Carrier's Austin Representative**

Box Number 01

**MFDR Date Received**

October 20, 2014

**REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "I would like to request assistance in obtaining the balance for the service provided on 06/10/2014. An attempt was made to the carrier in a request for reconsideration. The response was an EOB stating that The amount paid reflects a fee schedule reduction. The charge for this procedure exceeds the fee schedule allowance."

**Amount in Dispute:** \$450.00

**RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on October 28, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

**Response Submitted by:** NA

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 10, 2014	Designated Doctor Examination	\$450.00	\$450.00

**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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §133.204 sets out the procedures for billing and reimbursing Designated Doctor Examinations.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 1 – (P12) Workers’ compensation jurisdictional fee schedule adjustment.
  - 3 – (193) Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

**Issues**

1. What is the correct MAR for the services in dispute?
2. Is the requestor entitled to additional reimbursement?

**Findings**

1. Per 28 Texas Administrative Code §134.204 (j)(3), “The following applies for billing and reimbursement of an MMI evaluation. (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.” The submitted documentation indicates that the Designated Doctor performed an evaluation of Maximum Medical Improvement as ordered by the Division. **Therefore, the correct MAR for this examination is \$350.00.**  
 Per 28 Texas Administrative Code §134.204 (j)(4), “The following applies for billing and reimbursement of an IR evaluation. (C)(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.” The submitted documentation indicates that the Designated Doctor performed a full physical evaluation with range of motion for the right upper extremity to find the Impairment Rating. **Therefore, the correct MAR for this examination is \$300.00.** Further, the submitted documentation indicates that the Designated Doctor obtained the Impairment rating of the cervico-thoracic spine using the DRE method. **Therefore, the correct MAR for this examination is \$150.00.**
2. Review of the submitted documentation finds that the requestor billed for a Designated Doctor Examination totaling \$800.00. The insurance carrier paid \$350.00. The requestor is entitled to an additional reimbursement of \$450.00.

**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 \$450.00.

**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 \$450.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

Signature	<b>Laurie Garnes</b> Medical Fee Dispute Resolution Officer	<b>January 20, 2015</b> 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.**