TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
John F. Davis, D.C.

Respondent Name
Zurich American Insurance Company

MFDR Tracking Number
M4-17-0742-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 16, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = 350.00
IR w/ ROM = 300.00
Back IR = 150.00
Total Paid = 650.00
Balance Due = 150.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 7, 2016	Designated Doctor Examination	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable 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 the fee guidelines for division-specific services from March 1, 2008 until September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

- W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal.

Issues

1. Did Zurich American Insurance Company respond to the medical fee dispute?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the John F. Davis, D.C. entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Zurich American Insurance Company (Zurich) is Flahive, Ogden and Latson. Flahive, Ogden and Latson acknowledged receipt of the copy of this medical fee dispute on November 21, 2016.

   28 Texas Administrative Code §133.307 states, in relevant part:

   > (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
   > (1) Timeliness. 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** [emphasis added]. 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.

   Review of the documentation finds that no response has been received from Flahive, Ogden and Latson to date. The division concludes that the carrier failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

2. John F. Davis, D.C. is seeking an additional $150.00 reimbursement for a designated doctor examination to determine maximum medical improvement (MMI) and impairment rating (IR) performed on January 7, 2016. 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 supports that Dr. Davis performed an evaluation of Maximum Medical Improvement. Therefore, the MAR for this examination is $350.00.

   Reimbursement for examinations to determine impairment rating are based upon the number of body areas for which an impairment rating is assigned. 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.
   > (i) Musculoskeletal body areas are defined as follows:
   > (I) spine and pelvis;
   > (II) upper extremities and hands; and,
   > (III) lower extremities (including feet).
   > (ii) The MAR for musculoskeletal body areas shall be as follows…
   > (II) If full physical evaluation, with range of motion, is performed:
   > (-a-) $300 for the first musculoskeletal body area.
   > (-b-) $150 for each additional musculoskeletal body area.

   In addition, 28 Texas Administrative Code §134.204(j)(2)(b) states:

   > If the examining doctor determines MMI has been reached and there is no permanent impairment because the injury was sufficiently minor, an IR evaluation is not warranted and only the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection.

   Submitted documentation finds that an impairment rating was provided for the lumbar spine and "no impairment given for the left foot sprain." Therefore, the MAR for this examination is $300.00.

3. The total MAR for the disputed services is $650.00. Zurich paid $650.00. No further reimbursement is recommended.

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 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	December 30, 2016
Signature	Medical Fee Dispute Resolution Officer	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, 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 MFDR 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.