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
James Butler, M.D.

Respondent Name
Travelers Indemnity Company

MFDR Tracking Number
M4-18-1639-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
January 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "POST DESIGNATED DOCTOR EXAM INCORRECT REDUCTION"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "When evaluating a psychological injury, on is evaluating an injury to the brain. This constitutes a non-musculoskeletal body area, as defined in Rule 134.250(4)(D)(i)(II). As such, Rule 134.250(4)(D) requires the Provider to bill the appropriate CPT code for the testing to that non-musculoskeletal body are when determining impairment. The Provider herein billed only CPT code 99456, and did not submit any other CPT codes on the billing for this date of service."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 20, 2017	Examination to determine maximum medical improvement and impairment rating	$150.00	$150.00

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 §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment ratings.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Dr. Butler is seeking an additional reimbursement of $150.00 for an examination to determine maximum medical improvement (MMI) and impairment ratings (IR) for three body areas.

The fee for determination of MMI is $350.00.[1] The submitted evidence supports that Dr. Butler provided an assessment of MMI.

The fee for assignment of an IR of a musculoskeletal body area that includes range of motion testing is $300.00 and $150.00 for any additional musculoskeletal body areas.[2] The fee for the **assignment** of an IR of a non-musculoskeletal body area is $150.00.[3] The submitted documentation supports that Dr. Butler assessed impairment ratings for the lumbar spine, right leg, and emotional/behavioral conditions.

The division concludes that the total allowable reimbursement is $950.00. The insurance carrier reimbursed $800.00. An additional reimbursement of $150.00 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 on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	August 2, 2018
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 Rule §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 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. **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.

[1] 28 Texas Administrative Code §134.250(3)(C)
[2] 28 Texas Administrative Code §134.250(4)(C)
[3] 28 Texas Administrative Code §134.250(4)(D)(v)