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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Emily Bailey, D.C.

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-18-2181-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
February 22, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "MMI = $350.00
IR-W/ROM = $300.00
TTL = $650.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Designated Doctor does not indicate that ROM (Range of Motion) was the factor for the impairment rating nor does she substantiate in her report that ROM is being utilized to determine the DRE (Diagnosis Related Estimates) category for the Lumbar and/or Thoracic Spine."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 2017	Designated Doctor Examination	$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 §134.1 sets out the guidelines for medical fee reimbursement.
3. 28 Texas Administrative Code §134.209 defines the applicability of the division's fee guidelines for division-specific services.
4. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 131 – Claim specific negotiated discount.
   - 197 – Recommended allowance based on negotiated discount/rate.
   - W3 – Additional payment made on appeal/reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Emily Bailey, D.C. is seeking additional reimbursement for a designated doctor examination performed on November 14, 2017. The insurance carrier reduced the reimbursement based on a negotiated rate.

   A designated doctor examination is not subject to network negotiated rates.[1] The fees for a designated doctor examination are subject to the rules applicable to division-specific services. Therefore, the insurance carrier's reasons for reduction are not supported.

2. The maximum allowable reimbursement (MAR) for the determination of maximum medical improvement is $350.00.[2] The MAR for determination of an impairment rating for a musculoskeletal body area is $150.00 if the DRE method is used and $300.00 for the first body area if a full physical examination with range of motion is **performed**.[3]

   The documentation submitted to the division indicates that Dr. Bailey determined the injured worker's maximum medical improvement and determined the impairment rating, performing a full physical examination with range of motion in conjunction with this examination.

   The total MAR for the examination in question is $650.00. The insurance carrier reimbursed $500.00. The division finds that Dr. Bailey is eligible for an additional reimbursement of $150.00. This amount 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	September 12, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §134.209(a)(5) and 28 Texas Administrative Code §134.1(c)
[2] 28 Texas Administrative Code §134.250(3)(C)
[3] 28 Texas Administrative Code §134.250(4)(C)(ii)

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.