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
Donald Gene Eaves, D.C.

Respondent Name
Zurich American Insurance Company

MFDR Tracking Number
M4-18-3445

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 17, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I performed an MMI examination on the above-mentioned claimant on 12.04.2017 as requested by the treating doctor to address the following Maximum Medical Improvement and Impairment Rating … It is my position the previous $300.00 reduction should be reimbursed as allowed by TDI DWC rules pertaining to the reimbursement of MMI/IR treating doctor referral examinations."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… the provider is entitled to reimbursement of only $350.00 unless the provider bills with a modifier of W5. Absent that, the reimbursement of $350.00 is appropriate."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 4, 2017	Referral Examination to Determine Maximum Medical Improvement and Impairment Rating (99456-WP)	$300.00	$300.00

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 §130.1 sets out the requirements for assigning maximum medical improvement and impairment rating.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.210 sets out the definitions of modifiers used in division-specific service billing codes.
4. 28 Texas Administrative Code §134.240 sets out the fee guidelines that apply to designated doctor

examinations.

5. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determination maximum medical improvement and impairment rating.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 18 – Exact duplicate claim/service.

Issues

Is Donald Gene Eaves, D.C. entitled to additional reimbursement for the examination in question?

Findings

Dr. Eaves is seeking an additional reimbursement of $300.00 for an examination to determine the injured worker's maximum medical improvement (MMI) date and permanent impairment rating (IR) performed on December 4, 2017.

In its position statement, Flahive, Ogden & Latson argued on behalf of Zurich American Insurance Company (Zurich) that "the provider is entitled to reimbursement of only $350.00 unless the provider bills with a modifier of W5."

The division has assigned modifier W5 for use when a designated doctor performs an examination to determine maximum medical improvement and impairment rating.[1] Submitted documentation does not support that the services in question were performed as a designated doctor examination ordered by the division.[2] Rather, the ample evidence presented by the requestor and information available to the division confirms that Dr. Eaves was performing the examination as a doctor selected by the treating doctor in place of the treating doctor.[3]

The maximum allowable reimbursement (MAR) for an examination to determine MMI is $350.00.[4] The MAR for an examination to determine IR when a full physical examination with range of motion is performed is $300.00.[5] The report presented by Dr. Eaves indicates that the doctor performed an examination to determine maximum medical improvement and an impairment rating which included a full physical examination with range of motion for the left knee.

The total MAR for the examination in question is $650.00. Zurich reimbursed $350.00. An additional reimbursement of $300.00 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 $300.00.

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 $300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

[1] 28 Texas Administrative Code §134.210(e)(20); 28 Texas Administrative Code §134.240(1)(A) & (B)
[2] Texas Labor Code §408.0041(a)
[3] 28 Texas Administrative Code §130.1(a)(1)(A)(i)
[4] 28 Texas Administrative Code §134.250(3)(C)
[5] 28 Texas Administrative Code §134.250(4)(C)

Authorized Signature

	Laurie Garnes	September 24, 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.