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
Norman Rittenberry, D.C.

Respondent Name
Travelers Indemnity Company

MFDR Tracking Number
M4-18-5273-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
August 28, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = $350.00
IR – W/ROM = $300.00
TTL = $650.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "For this CPT code, the Carrier reimbursed the Provider $350.00 for the Maximum Medical Improvement evaluation per Rule 134.250(3)(C), and $150.00 for the DRE impairment rating assignment per Rule 134.250(4)(C) and (D) … The Carrier contends the Provider is not entitled to additional reimbursement."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 24, 2018	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 §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
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.
- W3 – Additional payment made on appeal/reconsideration.
- 947 – Upheld. No additional allowance has been recommended.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Norman Rittenberry, D.C. is seeking additional reimbursement for a designated doctor examination performed on May 24, 2018. The maximum allowable reimbursement (MAR) for the determination of maximum medical improvement is $350.00.[1] 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**.[2]

The documentation submitted to the division indicates that Dr. Rittenberry determined the injured worker's maximum medical improvement and 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. Rittenberry 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

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	September 24, 2018 Date

[1] 28 Texas Administrative Code §134.250(3)(C)

[2] 28 Texas Administrative Code §134.250(4)(C)(ii); See also MFDR decisions m4150098 and m4173622 found at https://www.tdi.texas.gov/wc/admindecisions.html#mfdr

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.