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
Thomas Pfeil, Jr., M.D.

Respondent Name
Travelers Indemnity Company

MFDR Tracking Number
M4-18-5280-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
August 28, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "MMI = $350.00
IR – UPPER EXTREMITY = $300.00
IR – SKIN =$150.00
TTL =$800.00"

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 $300.00 for the ROM impairment rating assignment to the upper extremity (left hand) per Rule 134.250(4)(C) … As documented by the MMI report, the Provider did not perform range of motion testing. Therefore, the proper reimbursement for the Provider should have been $350.00 for the MMI evaluation and the $150.00 for the evaluation of the non-musculoskeletal body area of skin (laceration/scar and infection). In this case the Provider has been reimbursed in excess of the Maximum Allowable Reimbursement under the adopted Rules of the Division of Workers' Compensation, and the Carrier contends no additional reimbursement is due."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 31, 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.
   - 4150 An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed.
   - 863 – Reimbursement is based on the applicable reimbursement fee schedule.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that additional payment made on appeal/reconsideration.
   - W3 – 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

Is Thomas Pfeil, Jr., M.D. entitled to additional reimbursement?

Findings

Dr. Pfeil is seeking additional reimbursement for a designated doctor examination performed on May 31, 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 $300.00 for the first body area if a full physical examination with range of motion is performed.[2] The MAR for determination of an impairment rating for a non-musculoskeletal body area is $150.00.[3]

The documentation submitted to the division indicates that Dr. Pfeil determined the injured worker's maximum medical improvement and an impairment rating of the left hand and skin. The evidence presented indicates that Dr. Pfeil performed a full physical examination with range of motion of the left-hand ring and little fingers, including a copy of Figure 1, page 16 found in the AMA Guidelines with calculations. The narrative report states that the impairment rating for the skin was determined based on Table 2, page 280 of the AMA Guidelines.

The total MAR for the examination in question is $800.00. The insurance carrier reimbursed $650.00. The division finds that Dr. Pfeil 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.

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

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.