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
Lida Dahm, M.D.

Respondent Name
Zurich American Insurance Company of Illinois

MFDR Tracking Number
M4-19-1001-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 22, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "These services were requested and prescribed by the Division."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 5, 2018	Designated Doctor Examination	$650.00	$650.00

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 (DWC).

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 schedule 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:
   - B7

Issues

1. Did Zurich American Insurance Company of Illinois respond to the medical fee dispute?
2. Is the denial of payment for the disputed services supported.
3. Is Lida Dahm, M.D. entitled to additional reimbursement?

Findings

1. The insurance carrier's Austin representative acknowledged receipt of the copy of this medical fee dispute on October 29, 2018. The insurance carrier's response is considered timely if it is submitted within 14 calendar days after the date the insurance carrier's representative received the copy of the dispute. If a response is not received within 14 calendar days of the dispute notification, then the decision may be based on the available information.[1]

   No response has been received on behalf of Zurich American Insurance Company of Illinois (Zurich) to date. For that reason, the decision will be based on the information available.

2. Dr. Dahm is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating. Zurich denied the disputed services with claim adjustment reason code B7, which signifies "This provider was not certified/eligible to be paid for this procedure/service on this date of service."

   Information available supports that Dr. Dahm was certified to perform the designated doctor examination as ordered by the DWC. The denial of the disputed services is not supported.

3. The designated doctor is to bill an examination to determine maximum medical improvement with CPT code 99456 and modifier "W5."[2] Reimbursement is $350.00 for this examination.[3] The submitted documentation supports that Dr. Dahm performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

   The designated doctor is to bill an examination to determine the impairment rating of an injury with CPT code 99456 and modifier "W5."[4] Reimbursement is $300.00 for the first musculoskeletal body area.[5] The submitted documentation supports that Dr.Dahm provided an impairment rating, which included a musculoskeletal body part, performing a full physical evaluation with range of motion of the upper extremity. Therefore, the MAR for this examination is $300.00.

   The total MAR for the services in question is $650.00. 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 $650.00.

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 $650.00, 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 §133.307(d)(1)
[2] 28 Texas Administrative Codes §§134.250(3)(C) and 134.240(1)(B)
[3] 28 Texas Administrative Code §134.250(3)(C)
[4] 28 Texas Administrative Codes §§134.250(4)(A) and 134.240(1)(A)
[5] 28 Texas Administrative Codes §§134.250(4)(C)(ii)(II)(-a-)

Authorized Signature

	Laurie Garnes	January 18, 2019
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.