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
John Sklar, M.D.

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-19-1017

Carrier's Austin Representative
Box Number 45

MFDR Date Received
October 22, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = 350.00
Cervical IR w/ ROM = 300.00
Head IR = 150.00
Concussion IR = 150.00
Ear/Hearing Loss IR = 150.00
Chest IR = 150.00
Abdomen IR = 150.00
Stroke/Anxiety/Insomnia IR = 150.00
Granulomatous Disease IR = 150.00
Total Paid = 950.00"

Amount in Dispute: $750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dr. Sklar assessed impairment pursuant to the DWC 32 for the compensable injury by rating one body area cervical (spinal) and two non-musculoskeletal body areas which addressed the head contusion, concussion, chest and abdomen and calculated the impairment rating as prescribed by the Division. Therefore, the Office does not find that additional reimbursement is owed for impairment ratings for the compensable injury(s)."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 9, 2018	Designated Doctor Examination	$750.00	$450.00

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:

   Explanation of Benefits dated July 13, 2018:
   - 16 – Claim/service lacks information which is needed for adjudication.
   - 295 – Service cannot be reviewed without report or invoice. Please submit report/invoice as soon as possible to ensure accurate processing.

   Explanation of Benefits dated September 4, 2018:
   - W3 – Additional payment made on appeal/reconsideration.
   - 5080 – Based on the receipt of additional information and/or clarification, we are recommending further payment be made for the above noted procedure code(s).

   Explanation of Benefits dated October 8, 2018:
   - 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. Did the insurance carrier maintain its denial based on lack of information?
2. Is the requestor entitled to additional reimbursement for the services in question?

Findings

1. In its explanation of benefits dated July 13, 2018, State Office of Risk Management denied the disputed services based on a lack of information. The division finds that submitted documentation supports that the insurance carrier did not maintain this denial. Therefore, it will not be considered in this dispute.

2. Dr. Sklar is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating.

   The designated doctor (DD) is required to bill an examination to determine maximum medical improvement with CPT code 99456 and modifier "W5."[1] Reimbursement is $350.00 for this examination.[2] The submitted documentation supports that Dr. Sklar performed an evaluation of maximum medical improvement as ordered by the division. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

   The submitted documentation indicates that Dr. Sklar was ordered to address maximum medical improvement, impairment rating, and extent of injury. When a DD is required to perform these three examinations together, the DD shall bill and be reimbursed for all the body areas given impairment ratings.[3]

   Review of the submitted documentation finds that Dr. Sklar performed impairment rating evaluations related to the cervical spine, chest, abdomen, a stroke, anxiety, insomnia, granulomatous disease, the ear, and hearing loss. The examination of the cervical spine included range of motion testing. The MAR for the

[1] 28 Texas Administrative Codes §§134.250(3)(C) and 134.240(1)(B)
[2] 28 Texas Administrative Code §134.250(3)(C)
[3] 28 Texas Administrative Code §134.250(4)(B)

evaluation of a musculoskeletal body area performed with range of motion is $300.00.[4] The MAR for the evaluation of a non-musculoskeletal body area is $150.00.[5] The total MAR for the determination of impairment rating for the disputed services is $1,050.00.

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]		$350.00
IR: Cervical Spine (ROM)	Musculoskeletal System	Spine	$300.00
IR: Granulomatous Disease	Endocrine System	Body Systems	$150.00
IR: Head/Concussion	Nervous System	Body Systems	$150.00
IR: Stroke	Mental/Behavioral	Body Systems	$150.00
IR: Anxiety			
IR: Insomnia			
IR: Chest	Skin	Body Structures	$150.00
IR: Abdomen			
IR: Ear/Hearing	ENT & Related Structures	Body Structures	$150.00
Total MMI	[redacted]		**$350.00**
Total IR			**$1,050.00**
Total Exam			**$1,400.00**

The total MAR for the disputed services is $1,400.00. The insurance carrier paid $950.00. An additional reimbursement of $450.00 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 $450.00.

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 $450.00, 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	March 13, 2019 Date

[4] 28 Texas Administrative Code §134.250(4)(C)(ii)(II)(-a-)
[5] 28 Texas Administrative Code §134.250(4)(D)(v)

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.