TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Warwick Payne, D.C.

**Respondent Name**
Zurich American Insurance Company

**MFDR Tracking Number**
M4-19-2047-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
December 10, 2018

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "99456 W5 WP MMI = 350.00
IR w/ ROM = 300.00
Total Paid = 500.00
Balance Due = 150.00"

**Amount in Dispute:** $150.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The carrier's position is that the provider was entitled to reimbursement of $500.00 and the provider has been paid that amount."

**Response Submitted by:** Flahive, Ogden & Latson

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 26, 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 Codes §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.

**Issues**

Is Warwick Payne, D.C. entitled to additional reimbursement for the services in question?

**Findings**

Dr. Payne is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating.

The designated doctor 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. Payne performed an evaluation of maximum medical improvement as ordered by the DWC. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

The designated doctor is required to bill an examination to determine the impairment rating of an injury with CPT code 99456 and modifier "W5."[3] Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[4] The submitted documentation supports that Dr. Payne provided an impairment rating, which included a musculoskeletal body part, performing a full physical evaluation with range of motion of the elbow. Therefore, the MAR for this examination is $300.00.

The total allowable for the services in question is $650.00. The insurance carrier paid $500.00. An additional reimbursement of $150.00 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 $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**

| | Laurie Garnes | January 25, 2019 |
|---|---|---|
| Signature | Medical Fee Dispute Resolution Officer | Date |

[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 Codes §§134.250(4)(A) and 134.240(1)(A)
[4] 28 Texas Administrative Codes §§134.250(4)(C)(ii)(II)(-a-)

## *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**.