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
Robert Carroll, M.D.

Respondent Name
American Zurich Insurance Company

MFDR Tracking Number
M4-19-2403-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 31, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our office is seeking an additional $150.00 for Maximum Medical Improvement and Impairment rating. We received payment for 2 of 3 units. The cervical spine, ribs and knee are each an individual body area."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider certified the claimant at MMI and assigned an impairment rating. The provider billed $950.00. The carrier has reimbursed the provider the sum of $800.00. We are attaching a copy of the carrier's EOBs dated October 18, 2018 and November 28, 2018. It remains the carrier's position that the provider is entitled to reimbursement of $800.00 which has already been paid."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 29, 2018	Examination to Determine Maximum Medical Improvement and Impairment Rating	$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.

- Notes: “No allowance change”

Issues

Is Robert Carroll, M.D. entitled to additional reimbursement?

Findings

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

The doctor selected by the treating doctor acting in place of the treating doctor is required to bill an examination to determine maximum medical improvement with CPT code 99456.”[1] Reimbursement is $350.00 for this examination.[2] The submitted documentation supports that Dr. Carroll performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

Review of the submitted documentation finds that Dr. Carroll performed impairment rating evaluations of rib contusions, the cervical spine, and right knee. The MAR for the evaluation of right knee, a musculoskeletal body area performed with range of motion is $300.00.[3] The MAR for the evaluation of subsequent musculoskeletal body area, the cervical spine, is $150.00.[4] The MAR for the evaluation of non-musculoskeletal body, area rib contusions, is $150.00.[5] The total MAR for the determination of impairment rating is $600.00.

The total allowable reimbursement is $950.00 for the services in question. The insurance carrier paid $800.00. 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 Code §134.250(4)(C)(ii)(II)(-a-)
[4] 28 Texas Administrative Code §134.250(4)(C)(ii)(II)(-b-)
[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.