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
TASB Risk Management Fund

MFDR Tracking Number
M4-19-2678-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
January 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE DOCTOR WAS REQUESTED TO DO A DD EVALUATION FOR AN IMPAIRMENT RATING AND EXTENT OF INJURY. AS A PART OF THEE EXTENT ADDITIONAL AREAS WERE RATED BY THE DD. THERE WERE 2 COMPENSABLER AREAS AND 4 AREAS NOT COMPENSABLE, BUT ALL AREAS WERE RATED."

Amount in Dispute: $600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment of $350.00 was made for the MMI examination. Payment of $450 was made for the Impairment Ratings ($300-ROM, $150-DRE)…"

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 8, 2018	Designated Doctor Examination	$600.00	$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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- W3 – Additional payment made on appeal/reconsideration.
- Notes: "Maintaining original reimbursement MMI - $350 + ROM of UE (shoulder) $300 + DRE - $150

Issues

Is the requestor entitled to additional reimbursement?

Findings

Dr. Carroll is seeking an additional reimbursement of $600.00 for a designated doctor examination to determine the maximum medical improvement and impairment rating for the injured employee.

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. Carroll performed an evaluation of maximum medical improvement as ordered by the division. 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

- Dizziness
- Right Shoulder, performing range of motion testing
- Morbid Obesity
- Depression
- Vertigo
- Pre-diabetes
- Headaches

The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[3] The MAR for the evaluation of each non-musculoskeletal body area is $150.00.[4] The total allowance for this examination is calculated as follows:

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]		$350.00
IR: Right Shoulder (ROM)	Musculoskeletal System	Upper Extremities	$300.00
IR: Dizziness	Nervous System	Body Systems	$150.00
IR: Vertigo			
IR: Headaches			
IR: Depression	Mental/Behavioral	Body Systems	$150.00
IR: Morbid Obesity	Digestive System	Body Systems	$150.00
IR: Pre-Diabetes	Endocrine System	Body Systems	$150.00
Total MMI	[redacted]		**$350.00**
Total IR			**$900.00**
Total Exam			**$1,250.00**

The total MAR for the determination of impairment rating is $900.00. The total allowable for the examination in question is $1,250.00. TASB Risk Management Fund reimbursed $800.00. An additional $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.

[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)(D)(v)

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

	Laurie Garnes	February 8, 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.