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
John Sklar, M.D.

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-19-2901-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
January 28, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = 350.00
IR Cervical = 300.00
IR Head = 150.00
IR TMJ = 150.00
IR – Stroke/Epilepsy/Mood Disorder = 150.00
Total = 1,100.00"

Amount in Dispute: $150.00

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 (Head and Jaw) areas which addressed the head contusion, concussion, 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
June 20, 2018	Designated Doctor Examination	$150.00	$0.00

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:
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 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

Is the requestor entitled to additional reimbursement?

Findings

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]

The division finds that the submitted documentation provides evidence that Dr. Sklar performed impairment rating evaluations of the nervous system, with "percent impairment(s) obtained from tables 1 through table 6 chapter 4 pages 141-143." No evidence was presented to support that Dr. Sklar performed impairment evaluations of body areas other than the nervous system.[4] The MAR for the evaluation of a non-musculoskeletal body area is $150.00.[5] Therefore, the MAR for the determination of the impairment rating for the disputed service is $150.00.

The total MAR for the examination in question is $500.00 The insurance carrier reimbursed $950.00. No further reimbursement is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

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[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)(A) and (B); "Subsection (j) of this section maintains the provision that when performing an IR evaluation, body areas are reimbursed as well, **and also** maintains an **additional** reimbursement of $50 for each additional IR calculation when multiple IRs are required as a component of a designated doctor examination." 33 TexReg 364
https://texreg.sos.state.tx.us/public/regviewer$ext.RegPage?sl=T&app=2&p_dir=F&p_rloc=176378&p_tloc=177490&p_ploc=158064&pg=10&p_reg=200706640&ti=&pt=&ch=&rl=&z_chk=49691
[4] 28 Texas Administrative Code §134.250(1)(D)
[5] 28 Texas Administrative Code §134.250(4)(D)(v)

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	March 7, 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.