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
Truck Insurance Exchange

MFDR Tracking Number
M4-19-3292-01

Carrier's Austin Representative
Box Number 14

MFDR Date Received
February 27, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = $350.00
IR – UPPER EXTREMITY = $300.00
IR – LOWER EXTREMITY = $150.00
IR – SKULL FX = $150.00
IR – HERNIA = $150.00
IR – MASTOID FX = $150.00
IR – HEARING = $150.00
TTL = $1550.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier properly calculated reimbursement in this case and stands by the reasons for reduction of payment set forth in its Explanation of Benefits previously filed in this dispute."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 8, 2018	Designated Doctor Examination (99456-W5-WP x 7)	$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:
   - ORC – See Additional Information: "MMI/IR/ROM (6 AREAS)/BY RULE A MAX OF 3 MUSCULOSKELETAL IRs ARE PAYABLE. PLUS 3 NON-MUSCULOSKELETAL (HERNIA, HEADACHES, HEARING)"
   - P12 – Workers' Compensation State Fee Schedule Adj
   - Comments: "HCP is appealing and indicating the totals on their fax cover = $1550. This is incorrect. Total = $1400 which is what was paid for 99456-W5-WP. Additionally, HCP indicates 'IR-Skull FX' and 'IR-Mastoid FX' on two sep lines. Mastoid FX is skull fx. Max of THREE musculoskeletal areas can be paid for ROM: RUE, LUE, RLE (three); plus non-musculoskeletal (hernia, headache hearing). No additional allowed"

Issues

Is the requestor entitled to additional reimbursement?

Findings

Dr. Sklar is seeking an additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment. The insurance carrier reduced the payment citing the fee guidelines.

The submitted documentation supports that Dr. Sklar performed an evaluation of maximum medical improvement. The maximum allowable reimbursement (MAR) for this examination is $350.00.[1]

Review of the submitted documentation finds that Dr. Sklar performed impairment rating evaluations of multiple body areas, including musculoskeletal and non-musculoskeletal body areas. The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[2] The MAR for the evaluation of subsequent musculoskeletal body area areas is $150.00.[3] The MAR for the evaluation of non-musculoskeletal body areas is $150.00.[4]

The calculation for the reimbursement of the examination in question is as follows:

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]		$350.00
IR: Left Wrist/Right Shoulder Blade (ROM)	Musculoskeletal System	Upper Extremities	$300.00
IR: Right Lower Extremity (ROM)		Lower Extremities	$150.00
IR: Fractured Skull/Concussion/ TBI/Dizziness/Vertigo	Nervous System	Body Systems	$150.00
IR: Headaches			
IR: Hearing	Ear, Nose, Throat, & Related Structures	Body Structures	$150.00
IR: Mastoid Process Fracture			
IR: Umbilical Hernia	Digestive System	Body Systems	$150.00
Total MMI	[redacted]		**$350.00**
Total IR			**$900.00**
Total Exam			**$1,250.00**

The total allowable reimbursement is $1,250.00. The insurance carrier reimbursed $1,400.00. No further reimbursement is recommended.

[1] 28 Texas Administrative Code §134.250(3)(C)
[2] 28 Texas Administrative Code §134.250(4)(C)(ii)(II)(-a-)
[3] 28 Texas Administrative Code §134.250(4)(C)(ii)(II)(-b-)
[4] 28 Texas Administrative Code §134.250(4)(D)(v)

Conclusion

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.

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	June 11, 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.