TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
RMJ Evaluations, LLC

Respondent Name
Indemnity Insurance Company of North America

MFDR Tracking Number
M4-19-3736-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
April 8, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Review of submitted documentation finds that the doctor performed an evaluation of **Maximum Medical Improvement and Impartment Rating (MMI/IR)** for (4) body areas **$350.00**.
(1) Musculoskeletal body areas with **Range of Motion ROM** *Lower Extremities*, LEFT ANKLE **$300.00**.
(1st) Non- Musculoskeletal body areas with **Diagnosis Related Estimate DRE** *Body Systems* VASCULAR DISEASE **$150.00**.
(2nd) Non- Musculoskeletal body areas with **Diagnosis Related Estimate DRE** *Body Systems* THROMBOTIC DISORDERS **$150.00**.
(3rd) Non- Musculoskeletal body areas with **Diagnosis Related Estimate DRE** *Body Systems* RESPIRATORY IMPAIRMENT **$150.00**."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 18, 2018	Designated Doctor Examination	$300.00	$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:
   - 119 – Benefit maximum for this time period or occurrence has been reached.
   - 186 – Additional charges received, but no additional allowance is recommended due to the maximum allowance for this admission has been reached.
   - 6766 – Specialty bill audit/expert code review involving the application of code auditing rules and edits based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, and coding guidelines dev
   - 18 – Exact duplicate claim/service.
   - 247 – A payment or denial has already been recommended for this service.
   - W3 – Additional payment made on appeal/reconsideration.
   - 119 – Internal neurolysis no identified in the operative report.
   - 168 – Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - B12 – Services not documented in patients medical records.
   - 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

1. Did Indemnity Insurance Company of North America respond to the medical fee dispute?
2. Is the requestor entitled to additional reimbursement for the services in question?

Findings

1. The Austin carrier representative for Indemnity Insurance Company of North America is Downs Stanford, PC. Downs Stanford, PC acknowledged receipt of the copy of this medical fee dispute on April 16, 2019. Rule §133.307(d)(1) states that if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. The requester is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating.

   The submitted documentation supports that Milton Kirkwood, D.O. performed an evaluation of maximum medical improvement as ordered by the DWC. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.[1]

   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 non-musculoskeletal body areas is $150.00.[3] Documentation submitted to the DWC supports that Dr. Kirkwood performed evaluations of impairment for the left posterior malleolar fracture, left ankle syndesmosis, deep venous thrombosis, vascular disease, and a pulmonary embolism.

   Per the doctor's narrative, the impairment rating for the posterior malleolar fracture and left ankle syndesmosis including range of motion testing was based on the application of Table 42, page 78. The deep venous thrombosis impairment rating was determined using Table 69, page 89 and paragraph 7.7, page 207. The impairment rating for the pulmonary embolism was determined using Table 8, page 162 and Table 10, page 164.[4]

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[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)(D)(v)
[4] *AMA Guides to the Evaluation of Permanent Impairment*, 4th Edition

The DWC concludes that Dr. Khalifa is entitled to reimbursement as follows:

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement			$350.00
IR: Left Malleolar Fracture (ROM)	Musculoskeletal System	Lower Extremities	$300.00
IR: Left Ankle Syndesmosis (ROM)			
IR: Deep Venous Thrombosis	Hematopoietic System	Body Systems	$150.00
IR: Pulmonary Embolism	Respiratory System	Body Systems	$150.00
Total MMI			**$350.00**
Total IR			**$600.00**
Total Exam			**$950.00**

The total allowable for the dispute in question is $950.00. The insurance carrier reimbursed $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

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	August 16, 2019 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.