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
R. David Bauer, M.D.

Respondent Name
Service Lloyds Insurance Company

MFDR Tracking Number
M4-19-3779-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
April 12, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "MMI = $350.00
IR – KNEE W/ROM = $300.00
IR – HEAD CONT. = $150.00
IR – RIB CONT. = $150.00
IR – BACK STRAIN = $150.00
TTL = $1100.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider billed four musculoskeletal body areas Knee, Head, Rib, Back Strain thus the max of three are all that can be reimbursed per the TDI guidelines."

Response Submitted by: AViDEL

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 14, 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.

Issues

Is Dr. Bauer entitled to additional reimbursement for the services provided?

Findings

Dr. Bauer is seeking addition reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating.

The insurance carrier reduced the reimbursement citing the fee schedule. Explanation of benefits dated February 28, 2019 stated that "PER FEE SCHEDULE EXAMINING DOCTOR MAY BILL FOR A MAXIMUM OF THREE BODY AREAS. DOCUMENTATION SUPPORTS 1.THORACIC SPINE, 2.UPPER EXTREMITIES (HEAD &RIBS), 3. LOWER EXTREMITIES (KNEE). ADDITIONAL ALLOWANCE RANGE OF MOTION. $350 MMI EXAM, IR BY ROM 1ST BODY ARE $300, $150 EACH ADDITIONAL AREA."

A doctor performing an examination to determine impairment rating shall include the number of total body areas rated in the units column of the billing form.[1] The doctor may include up to three musculoskeletal body areas to include spine and pelvis, upper extremities and hands, and lower extremities including feet.[2] The doctor may also include any body systems, body structures including skin, and mental and behavioral conditions as determined by the AMA Guides.[3]

The submitted documentation supports that Dr. Bauer performed an evaluation of maximum medical improvement. The maximum allowable reimbursement (MAR) for this examination is $350.00.[4]

Review of the submitted documentation finds that Dr. Bauer performed impairment rating evaluations of contusions of the head and ribs, a strain/contusion of the thoracic spine, and sprain of the medial collateral ligament of the right knee.

The MAR for the evaluation of the right knee performed with range of motion is $300.00.[5] The MAR for the evaluation of a subsequent musculoskeletal body area, the thoracic spine, is $150.00.[6] The MAR for the evaluation of a non-musculoskeletal body structure, skin contusions to the head and ribs, is $150.00.[7] The total MAR for the determination of impairment rating is $600.00.

The total allowable reimbursement for the examination in question is $950.00. The insurance carrier reimbursed this amount. No further reimbursement is recommended.

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	May 29, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §134.250(4)(A)
[2] 28 Texas Administrative Code §134.250(4)(C)
[3] 28 Texas Administrative Code §134.250(4)(D)
[4] 28 Texas Administrative Code §134.250(3)(C)
[5] 28 Texas Administrative Code §134.250(4)(C)(ii)(II)(-a-)
[6] 28 Texas Administrative Code §134.250(4)(C)(ii)(II)(-b-)
[7] 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.