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
Benjamin Burris, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-19-4256-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
May 28, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our office is seeking an additional $150.00 for Maximum Medical Improvement and Impairment rating. We received payment for 3 of 4 units. Claim was billed as follows:

(a) $350.00 for maximum medical improvement
(b) $300 for the first musculoskeletal body area AND
(c) $150 for each additional musculoskeletal body area
(d) *$150 for each additional **non-musculoskeletal** body area*"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider billed for a disability exam and was paid for the following:
$350 – MMI
$300 – 1st body area- ROM lower extremity
$150 – 2nd body area- ROM upper extremity
$150 – DRE – eye"

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2019	Examination to Determine Maximum Medical Improvement & Impairment Rating	$150.00	$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:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 891 – No additional payment after reconsideration

Issues

Is Dr. Burris entitled to additional reimbursement?

Findings

This dispute involves additional reimbursement for an examination to determine maximum medical improvement performed on February 28, 2019. The submitted documentation supports that Dr. Burris 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]

Review of the submitted documentation finds that Dr. Burris performed impairment rating evaluations of the left upper extremity, the left lower extremity, the lumbar spine, and a left eye laceration. The MAR for the evaluation of the left upper extremity, a musculoskeletal body area performed with range of motion is $300.00.[2] The MAR for the evaluation of the left lower extremity, a subsequent musculoskeletal body area is $150.00. The MAR for the evaluation of the lumbar spine, a subsequent musculoskeletal body area is $150.00.[3] The MAR for the evaluation of the left eye, a non-musculoskeletal body area is $150.00.[4] The total MAR for the determination of impairment rating is $750.00.

The total allowable for the examination in question is 1,100.00. The insurance carrier reimbursed $950.00. 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

	Laurie Garnes	July 24, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[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)

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.