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
George Cole, D.O.

Respondent Name
Zurich American Insurance Company

MFDR Tracking Number
M4-19-4391-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = $350.00
IR – UPPER EXTREMITY = $300.00
IR – BACK =$150.00
TTL = $800.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier's position is that the provider has been reimbursed all that he is entitled to."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 30, 2019	Designated Doctor Examination	$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:
   - 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 developed by national societies and prevailing industry standards and coding practices.
- 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.
- 285 – Please refer to the note above for a detailed explanation of the reduction.
- Note: "The reconsideration request indicates that the total for the MMI and IR is $800. Based on our recommended allowance on the amount previously reimbursed, $350 was recommended for the MMI, $300 for the 1st musculoskeltal body area for the IR, $150 for the 2nd musculoskeletal body area for the IR. This totals $800. The first line was recommended at $650 (MMI and IR for the 1st area), and the second line was recommended at $150 (IR for the 2nd area). Line three was for the return to work exam based on modifier RE, which has an allowance of $500. All total the maximum eligible is $1,300 per 28 TAC §134.250. this supports the calculation provided on the fax cover sheet and from the provider stating TTL = $800. Consequently, no additional reimbursement is due based on regulations, the provider's own calculations, and the previous allowance."
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 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. Cole is seeking reimbursement for a designated doctor examination that included determination of maximum medical improvement and impairment rating for two body areas.

Dr. Cole also performed an examination to determine the extent of the compensable injury and provided multiple impairments to address each reasonable outcome. These services were reimbursed by the insurance carrier and are not considered part of this dispute.

The submitted documentation supports that Dr. Cole performed an evaluation of maximum medical improvement as ordered by the DWC. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

Review of the submitted documentation finds that Dr. Cole performed impairment rating evaluations of the right upper extremity and the lumbar spine as ordered by the DWC. The MAR for the evaluation of the right upper extremity, a musculoskeletal body area performed with range of motion is $300.00.[1] The MAR for the evaluation of the lumbar spine, a subsequent musculoskeletal body area, is $150.00.[2] The total MAR for the determination of impairment rating is $450.00.

The total allowable reimbursement for the examination in question is, therefore, $800.00. The insurance carrier reimbursed $650.00. An additional $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.

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

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 12, 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.