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
Pacific Billing Services, Inc.

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-19-4395-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = 350.00
Upper Extremities IR w/ ROM = 300.00
Nose Abrasion/Face IR = 150.00
Forehead Contusion IR = 150.00
Abdominal Wall IR = 150.00
Knee IR = 150.00
Total Paid = 950.00
Balance Due = 300.00"

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment of $350.00 was made for the MMI examination
Payment of $600.00 was made for the Impairment Rating (ROM)
Payment of $500 was made for Return to Work
Total payment of $1450.00 was reimbursed"

Response Submitted by: TASB Risk Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 9, 2019	Designated Doctor Examination	$300.00	$300.00

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:
   - P12 – DDE + ROM OF UE, LE. Workers' compensation jurisdictional fee schedule adjustment.
   - W3 – Additional payment made on appeal/reconsideration. 03/15/19 – Rule 134.804(a) Services reviewed for reconsideration. Additional payment made or service adjustment amount may be zero. 03/15/19 Allowing an additional $150. 00 for abdominal IR.

Issues

Is the requestor entitled to additional reimbursement?

Findings

This dispute involves additional reimbursement for an examination to determine maximum medical improvement performed by a designated doctor. The submitted documentation supports that Dr. Juan Quiroz 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. Quiroz performed impairment rating evaluations of a right thumb sprain, right wrist sprain, forehead contusion, forehead abrasion, nose abrasion, abdominal wall contusion, left knee contusion, and left knee abrasion. The MAR for the evaluation of one musculoskeletal body area performed with range of motion is $300.00.[2] The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00.[3] The MAR for the evaluation of non-musculoskeletal body areas is $150.00.[4] The calculation for the examination in question, based on the documentation presented, is as follows:

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]	[redacted]	$350.00
IR: Right Thumb Sprain (ROM)	Musculoskeletal System	Upper Extremities	$300.00
IR: Right Wrist Sprain (ROM)			
IR: Left Knee Contusion (ROM)		Lower Extremities	$150.00
IR: Forehead Contusion	Nervous System	Body Systems	$150.00
IR: Abdominal Wall Contusion			
IR: Forehead Abrasion	Skin	Body Structures	$150.00
IR: Left Knee Abrasion			
IR: Nose Abrasion	Ear, Nose, Throat, & Related Systems	Body Systems	$150.00
Total MMI	[redacted]	[redacted]	**$350.00**
Total IR			**$900.00**
Total Exam			**$1,250.00**

The total MAR for the determination of impairment rating is $1,250.00. The insurance carrier reimbursed $950.00. An additional $300.00 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 $300.00.

[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)

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 $300.00, 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 25, 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.