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
Worth Casualty Company

MFDR Tracking Number
M4-19-5111-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
August 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = $350.00
IR – HIP = $300.00
IR – BACK = $150.00
IR – EYES = $150.00
IR – TINNITUS = $150.00
IR – CONCUSSION = $150.00
IR – HEAD LACERATION = $150.00
TTL = $1400.00"

Amount in Dispute: $200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Salus determined that the original review was correct. CorVel allowed 2 Musculoskeletal body areas (Spine and Hip) $450, 3 Non-Musculoskeletal body areas (Eyes and Tinnitus are body systems; head laceration is body structure and concussion $450) plus MMI = $1200"

Response Submitted by: Salus

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 6, 2019	Designated Doctor Examination	$200.00	$200.00

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 ratings.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' Compensation State Fee Schedule Adj
   - ORC – See Additional Information
   - Notes: "ALLOWED 2 MUSCULOSKELETAL (SPINE & HIP $450) AND 3 NON MUSCULOSKELETAL (EYES & TINNITUS ARE BODY SYSTEMS; HEAD LAC IS BODY STRUCTURE AND CONCUSSION IS MENTAL, $450)+$350 MMI = $1200"

Issues

Is the requestor entitled to additional reimbursement?

Findings

Pacific Billing Services, Inc. is seeking reimbursement for a designated doctor examination performed by Dr. John Sklar on February 6, 2019. The insurance carrier reduced reimbursement citing the fee guideline.

The submitted documentation supports that Dr. Sklar performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.[1]

Review of the submitted documentation finds that Dr. Sklar performed impairment rating evaluations of six body areas:

- Left hip, with range of motion testing;
- Cervical and lumbar spine;
- Eyes/vision;
- Tinnitus;
- Head laceration; and
- Concussion.

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 a subsequent musculoskeletal body area is $150.00 each.[3] The MAR for the evaluation of non-musculoskeletal body areas is $150.00.[4] While musculoskeletal body areas are limited to three units,[5] the number of units for non-musculoskeletal body areas is determined by areas defined by the AMA Guides.[6]

Salus did not dispute the number of body areas asserted by the requestor. Therefore, the DWC concludes that the total MAR for the determination of impairment rating is $1,050.00. The total allowable for the examination in question is $1,400.00. The insurance carrier reimbursed $1,200.00. An additional $200.00 is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $200.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $200.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

[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)
[5] 28 Texas Administrative Code §134.250(4)(C)
[6] 28 Texas Administrative Code §134.250(4)(D)(ii)

Authorized Signature

	Laurie Garnes	September 6, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.