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
SCHNERINGER, JESSE OWEN

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-20-0428-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
October 17, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I was ordered to perform MMI/IR/EOI/RTW. Several of the disputed conditions were determined to be at MMI, range of motion of the lumbar spine was measured according to AMA Guidelines, and an impairment rating was calculated for these conditions…"

Amount in Dispute: $400.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Dr. Schneringer opined that the Claimant was not at MMI when evaluating (1) only the accepted condition, a lumbar strain … and (2) the accepted condition of lumbar strain and the conditions that the doctor determined to be compensable, lumbar osteophyte complex … Each of these is a reasonable outcome of the extent of injury dispute.

However, Dr. Schneringer determined that the Claimant was at MMI for three conditions that SORM had disputed as not compensable in which Dr. Schneringer also determined were not compensable (Lumbar Spondylosis, other intervertebral conditions, and other specified diseases of intestine)."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 18, 2019	99456-W5-WP	$300.00	$300.00
April 18, 2019	99456-W5-MI	$50.00	$0.00
April 18, 2019	99456-W5-MI	$50.00	$0.00
	Total	$400.00	$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 (DWC).

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:
   - W3 – Additional payment made on appeal/reconsideration.
   - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

Is Dr. Schneringer entitled to additional reimbursement for the examination in dispute?

Findings

Dr. Schneringer is seeking additional reimbursement for an examination to determine impairment rating with multiple impairment ratings. The examination also included a determination of extent of injury.

The submitted documentation supports that Dr. Schneringer provided an impairment rating of the spine, which is found in Chapter 3, Section 3 of the AMA Guides. The physical examination included range of motion testing. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[1] The documentation submitted does not include impairment ratings of any other body areas.

When multiple **impairment ratings** are required as a component of a designated doctor examination, the designated doctor shall be reimbursed $50 for each **additional impairment calculation**. In its review of the submitted documents, the DWC finds that only one impairment rating calculation was provided. No reimbursement is recommended for this service.

The total allowable reimbursement for the services in dispute is $300.00. This amount 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 $300.00.

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 $300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	November 19, 2019 Date

[1] 28 TAC §134.250(4)(C)(ii)(II)(-a-)

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.