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
OWUSU, ANTHONY JR

Respondent Name
SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number
M4-20-0500-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
October 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION … THE FACE IS CONSIDERED TO BE A SEPERATE BODY AREA FROM THE UPPER EXTREMITY."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The documentation for ROM only documents two body areas as follows: Cervical/Thoracic spine = 1 body area and Upper Extremity Right Shoulder = 1 body area thus only two body areas identified and reimbursed accordingly."

Response Submitted by: AViDEL

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 3, 2019	Designated Doctor Examination	$300.00	$0.00

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:
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

- Notes: “DOCUMENTATION SUPPORTS MMI EXAM AND IMPAIRMENT RATING USING RANGE OF MOTION FOR 2 BODY AREAS: SPINE (THORACIC) AND UPPER EXTREMITIES (SHOULDERS, FACE, CHEST, RIBS)
- 375 – See special *NOTE* below
- Notes: “STANDING ON PRIOR REVIEW”

Issues

Is Dr. Owusu entitled to additional reimbursement?

Findings

Dr. Owusu is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating. The insurance carrier reduced its reimbursement of the requested amount citing the fee guidelines.

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

Review of the submitted documentation finds that Dr. Owusu performed impairment rating evaluations of a sprain/strain of the right shoulder, facial abrasion, and rib and chest contusions.

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 non-musculoskeletal body areas is $150.00 each.[3]

Dr. Owusu determined the impairment of the right shoulder, a musculoskeletal body area, and performed a full examination with range of motion. The reimbursement for the impairment rating of this body area is $300.00.

Dr. Owusu determined the impairment of a facial abrasion and rib/chest contusions, a non-musculoskeletal body area. The reimbursement for this body area is $150.00.

The total allowable reimbursement for the examination in question is $800.00. This is the amount reimbursed by the insurance carrier. No additional reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

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

[1] 28 TAC §134.250(3)(C)
[2] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[3] 28 TAC §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 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.