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
BURRIS, BENJAMIN S.

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-20-0531-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
October 24, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CERTIFYING EXAMINATION INCORRECT REDUCTION"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The examining doctor assessed the injured employee to be at MMI pursuant to the DWC 69 for the compensable injury and assessed an impairment rating for the compensable body areas.

Based on the documentation included with the dispute packet, the exam reimbursed as follows which is in accordance with the aforementioned rules:

CPT 99456 WP X 4 units (MMI, IR-upper extremity (ROM), lower extremity, spine and jaw) $1,100.00"

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 21, 2019	Examination to Determine Maximum Medical Improvement and Impairment Rating	$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:
   - W3 – Additional payment made on appeal/reconsideration.

- 5080 – Based on the receipt of additional information and/or clarification, we are recommending further payment be made for the above noted procedure code(s).
- 18 – Exact duplicate claim/service
- 247 – A payment or denial has already been recommended for this service.

Issues

Is Dr. Burris entitled to additional reimbursement?

Findings

Dr. Burris seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating of five body areas. In its position statement, the insurance carrier indicated that it had paid based on four body areas.

The submitted documentation supports that Dr. Burris 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. Burris performed impairment rating evaluations of the left elbow, left knee and ankle, cervical and lumbar spine, jaw contusion, and sprain of the temporomandibular joint.

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 subsequent musculoskeletal body areas is $150.00.[3] The MAR for the evaluation of non-musculoskeletal body areas is $150.00 each.[4]

Dr. Burris determined the impairment of the left elbow, 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. Burris determined the impairment of the left knee and ankle, a musculoskeletal body area, and performed a full examination with range of motion. The reimbursement for the impairment rating of this body area is $150.00.

Dr. Burris determined the impairment of the cervical and lumbar spine, a musculoskeletal body area, and performed a full examination with range of motion. The reimbursement for the impairment rating of this body area is $150.00.

Dr. Burris determined the impairment of the jaw contusion, a non-musculoskeletal body area, referencing Chapter 9 (Ear, Nose, Throat and Related Structures) of the AMA Guides. The reimbursement for this body area is $150.00.

Dr. Burris determined the impairment of the sprain of the temporomandibular joint, a non-musculoskeletal body area, referencing Chapter 4 (Nervous System) of the AMA Guides. The reimbursement for this body area is $150.00.

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

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]		$350.00
IR: Left Elbow (ROM)	Musculoskeletal System	Upper Extremities	$300.00
IR: Left Leg/Ankle (ROM)		Lower Extremities	$150.00
IR: Cervical/Lumbar Spine (ROM)		Spine	$150.00
IR: Jaw Contusion	Ear, Nose, Throat & Related Structures	Body Structures	$150.00
IR: TMJ Sprain	Nervous System	Body Systems	$150.00
Total MMI	[redacted]		**$350.00**
Total IR			**$900.00**
Total Exam			**$1,250.00**

The total MAR for the disputed examination is $1,250.00. The insurance carrier reimbursed $1,100.00. An additional reimbursement of $150.00 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 $150.00.

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 $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	November 22, 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.