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
SKLAR, JOHN ANTHONY

Respondent Name
Zurich American Insurance Company

MFDR Tracking Number
M4-20-0752-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 22, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Sklar was the designated doctor on this case and was asked to address MMI and impairment for the Texas Department of Insurance. Per TDI fee schedule MMI and impairment to be reimbursed accordingly:

MMI $350.00
ROM (shoulder) $300.00
Left Knee/ankle $150.00
Head/scalp $150.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on a review of the Designated Doctor Examination report, reimbursement for the two (2) musculoskeletal areas totaled $450.00 for the impairment rating examination, with $350.00 for the MMI evaluation. In total, the documentation supported $800.00, which was previously reimbursed to the provider."

Response Submitted by: Equian

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 31, 2019	Designated Doctor Examination	$150.00	$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:
   - 119 – Benefit maximum for this time period or occurrence has been reached.
   - 186 – Additional charges received, but no additional allowance is recommended due to the maximum allowance for this admission has been reached.
   - 6766 – Specialty Bill Audit/Expert Code Review involving the application of code auditing rules and edits based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, and coding guidelines dev
   - 18 – Exact duplicate claim/service.
   - 247 – A payment or denial has already been recommended for this service.
   - W3 – Additional payment made on appeal/reconsideration.
   - 119 – Internal neurolysis not identified in the operative report.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 285 – Please refer to the note above for a detailed explanation of the reduction.
   - B12 – Services not documented in patients medical records
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
   - 285 Notes: "Head/Scalp is not a musculoskeletal body area according to the Texas guidelines. Also, on page 10 it is documented that 'The head injury Impairment includes the injury of a laceration to a scalp which does not give a ratable impairment. There is no impairment for the meniscal findings on MRI. According to the Texas guideline, If the treating/examining doctor determines that MMI has been reached and there is no permanent impairment because the injury was sufficiently minor: 1. An IR evaluation is not required 2. And only the MMI evaluation portion of the examination is billed and reimbursed. (28 TAC 130.1)"

Issues

Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

Dr. Sklar is seeking additional reimbursement for a designated doctor examination performed on July 31, 2019. The insurance carrier reduced payment citing fee guidelines.

In its position statement, Equian argued on behalf of the insurance carrier that, "the Designated Doctor states that the head injury impairment includes the injury of laceration to a scalp which does not give a ratable impairment … Given this statement and the sufficiently minor injury … the impairment rating of the scalp is not reportable." The DWC agrees with this assessment.

Dr. Sklar performed an evaluation of maximum medical improvement. The maximum allowable reimbursement (MAR) for this examination is $350.00.[1] Dr. Sklar provided impairment ratings for the upper extremities and lower extremities. The examination included range of motion. The MAR for the evaluation of the upper extremities is $300.00.[2] The MAR for the evaluation of the lower extremities is $150.00.[3]

The total MAR for the determination of impairment rating is $800.00. This is the amount that the insurance carrier paid. No further reimbursement is recommended.

[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-)

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

	Laurie Garnes	December 13, 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.