



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

Respondent Name

TASB RISK MGMT FUND

MFDR Tracking Number

M4-20-1115-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

January 3, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: \$750.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "No additional payments were due since the additional impairment ratings given were for non-related conditions."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 23, 2019	Designated Doctor Examination	\$750.00	\$600.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers' compensation jurisdictional fee schedule adjustment.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - W3 – Additional payment made on appeal/reconsideration

- Notes: “Rule 134.804 (a) Services reviewed for reconsideration. Additional payment made or service adjustment amount may be zero.”
- Notes: “Maintaining original payment, the additional IR’s are for non-related conditions. The extent of injury portion was paid with the W6 modifier.”

Issues

Is Pacific Billing entitled to additional reimbursement for the examination in question?

Findings

Pacific Billing is seeking an additional \$750.00 for a designated doctor evaluation of impairment rating as part of an examination to determine maximum medical improvement, impairment rating, extent of injury, and return to work. The designated doctor is directed to bill for the total number of body areas rated.¹

Review of the health care provider’s submitted reconsideration statement states that Robby Rampy, M.D. provided impairment ratings of the shoulder, back, obesity, diabetes, hypertension, liver disease, and asthma. The submitted medical report finds that Dr. Rampy provided supported impairment ratings of shoulder, back, thyroid tumor/diabetes, hypertension, liver disease, and asthma.

The maximum allowable reimbursement (MAR) for the evaluation of a musculoskeletal body area performed with range of motion is \$300.00.² The MAR for subsequent musculoskeletal body areas is \$150.00 each. The MAR for the evaluations of non-musculoskeletal body areas is \$150.00 each.³ See below for the total MAR for the determination for the examination in question.

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement			\$350.00
IR: Left Shoulder (ROM)	Musculoskeletal System	Upper Extremities	\$300.00
IR: Cervical Spine (ROM)		Spine	\$150.00
IR: Thyroid Tumor	Endocrine System	Body Systems	\$150.00
IR: Diabetes			
IR: Hypertension	Cardiovascular System	Body Systems	\$150.00
IR: Asthma	Respiratory System	Body Systems	\$150.00
IR: Liver Disease	Digestive System	Body Systems	\$150.00
Total MMI			\$350.00
Total IR			\$1,050.00
Total Exam			\$1,400.00

The total allowable for the evaluation of impairment rating is \$1,400.00. The insurance carrier paid \$800.00. An additional reimbursement of \$600.00 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 \$600.00.

¹ 28 TAC §127.10; 28 TAC §134.250

² 28 TAC §134.250(4)(C)(ii)(II)(-a-)

³ 28 TAC §134.250(4)(D)(v)

ORDER

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. 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 \$600.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

April 28, 2020

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.