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
MEDICAL EVALUATORS OF TEXAS

Respondent Name
AIG PROPERTY CASUALTY CO

MFDR Tracking Number
M4-20-1754-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 17, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… this type of examination is to be billed and reimbursed as follows: If it is determined that a patient has reached MMI the Designated Doctor will charge $350.00 and will bill as 99456-W5. In addition to the $350.00 for MMI Assessment the Designated Doctor will charge $300.00 for the first area of examination when range of motion was performed, and $150.00 for each additional area of examination."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that it has reimbursed the provider in accordance with the Medical Fee Guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 10, 2019	Designated Doctor Examination	$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 (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 citing fee guidelines.

Issues

Is Medical Evaluators of Texas entitled to additional reimbursement for the examination in question?

Findings

Medical Evaluators of Texas is seeking an additional reimbursement for a designated doctor examination billed with procedure code 99456-WP-W5 with two units.

The submitted documentation supports that Rudolph Theobald, D.C. performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[1]

Review of the submitted documentation finds that Dr. Theobald performed impairment rating evaluations of the lower extremities and spine with range of motion testing. 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 each.[3] The total MAR for the determination of impairment rating in this examination is $450.00.

The total allowable reimbursement for the examination in question is $800.00. The insurance carrier paid $650.00. An additional reimbursement of $150.00 is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. 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

		June 4, 2020
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.

[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-)