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
FEDERATED MUTUAL INSURANCE CO

MFDR Tracking Number
M4-20-2151-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 4, 2020

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $450.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In order to pay for the disputed services the carrier would need a bill with the non-musculoskeletal areas either on a separate line or a separate bill."

Response Submitted by: Parker & Associates, LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 20, 2019	Examination to Determine Maximum Medical Improvement and Impairment Rating	$450.00	$450.00

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: “Per Texas workers’ compensation guidelines, the examining physician may bill for a MAXIMUM of three body parts – Spine and pelvis, upper extremities and hands, and lower extremities (including feet). Reimbursement is based on this.”
- Notes: “There will be no additional allowance at this time = Per rule 134.204 (4)(C) ‘For MUSCULOSKELTAL body areas the provider may bill for a maximum of THREE body areas. Rule 134.204 (4)(D) states when exams for NON MUSCULOSKELETAL body areas are performed, the provider must bill these separately, using the proper modifier. The provider may take this matter to Medical Fee Dispute Resolution for further disposition. Thank you.”

Issues

Is Benjamin S. Burris, M.D. entitled to additional reimbursement for the examination in question?

Findings

Dr. Burris is seeking an additional $450.00 for an examination to determine maximum medical improvement and impairment rating. The insurance carrier reduced reimbursement citing fee guidelines.

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 spine with pelvis, upper extremities, and lower extremities with range of motion testing. Dr. Burris also performed impairment ratings of the chest and ribs, the right eye, and a head injury.

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

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement			$350.00
IR: Spine and Pelvis (ROM)	Musculoskeletal System	Spine	$300.00
IR: Upper Extremities (ROM)		Upper Extremities	$150.00
IR: Lower Extremities (ROM)		Lower Extremities	$150.00
IR: Chest/Ribs	Respiratory System	Body Systems	$150.00
IR: Right Eye	Visual System	Body Systems	$150.00
IR: Head Injury	Nervous System	Body Systems	$150.00
Total MMI			**$350.00**
Total IR			**$1,050.00**
Total Exam			**$1,400.00**

The total MAR for the examination in question is $1,400.00. The insurance paid $950.00. An additional reimbursement of $450.00 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 $450.00.

[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)

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 $450.00, 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	June 8, 2020 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.