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
MCGARRAH, MICHAEL PAUL

Respondent Name
ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number
M4-20-2457-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 8, 2020

REQUESTOR'S POSITION SUMMARY

"When I performed the DD exam the accepted conditions from the 032 included 3 body areas. I examined all three areas with ROM and have billed accordingly and accurately."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

"The initial EOB recommended reimbursement of $1,200. This was based on reimbursement of $650 for the MMI and impairment rating portion of the exam, $50 on the basis of multiple impairment ratings and $500 for the extent of injury portion of the exam. That totals $1,200. The carrier has reimbursed the provider pursuant to the Medical Fee Guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 8, 2020	Designated Doctor Examination	$300.00	$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 §134.235 sets out the fee guidelines for examinations to determine the extent of a compensable injury.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.

Issues

1. Is the insurance carrier's reasons for reduction of payment supported?
2. Is Michael P. McGarrah, D.C. entitled to additional reimbursement for the examination in question?

Findings

1. Dr. McGarrah is seeking additional reimbursement for a designated doctor examination performed on February 8, 2020. The insurance carrier reduced payment citing medical necessity. Because the examination was ordered by the DWC, it is not subject to medical necessity denials. This reduction of payment is not supported.
2. The submitted documentation supports that Dr. McGarrah performed an evaluation of maximum medical improvement. The maximum allowable reimbursement (MAR) for this examination is $350.00.[1]

   The submitted documentation supports that Dr. McGarrah provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the upper extremities. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[2] No other impairment ratings were documented.

   The submitted documentation indicates that Dr. McGarrah performed an examination to determine the extent of the compensable injury. The MAR for this examination is $500.00.[3]

   The submitted documentation indicates that Dr. McGarrah was ordered to address maximum medical improvement, impairment rating, and extent of injury. The narrative report and enclosed forms support that these evaluations were performed, and one additional impairment rating was provided. Therefore, the correct MAR for this service is $50.00.[4]

   The DWC finds that the total allowable reimbursement for the examination in question is $1,200.00. The insurance carrier paid this amount. No further reimbursement 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. Though all the evidence may not have been discussed, it was considered. 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

Signature	Medical Fee Dispute Resolution Officer	July 24, 2020 Date

[1] 28 TAC §134.250(3)(C)
[2] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[3] 28 TAC §134.235
[4] 28 TAC §134.250(4)(B)

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.