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
GENEVA MEDICAL MGMT INC

Respondent Name
GRAPEVINE COLLEYVILLE ISD

MFDR Tracking Number
M4-20-2546-01

Carrier's Austin Representative
Box Number 55

MFDR Date Received
June 22, 2020

REQUESTOR'S POSITION SUMMARY

"$350.00 for exam + $300.00 for range of motion + $150 (x) 3 body area … We seek full reimbursement for the outstanding balance of $150.00 along with interest accrued …"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

The Austin carrier representative for Grapevine Colleyville ISD is Christopher Ameel, Attorney at Law. The representative was notified of this medical fee dispute on June 30, 2020. If the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.[1]

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 2, 2020	Designated Doctor Examination (99456-W5-26 and 99456-W5-TC)	$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.

[1] 28 TAC §133.307(d)(1)

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - Notes: "DD EXAM/MMI/IR/ROM SHOULDER/HIP-CORRECTED CLAIM"
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - Notes: "THIS WAS PAID CORRECTLY ON PREVIOUS APPEAL BILL … THERE ARE ONLY 2 BODY AREAS AS HIP AND SPINE ARE CONSIDERED TO BE 1 AND SHOULDER IS THE OTHER."

Issues

Is Geneva Medical Management, Inc. entitled to additional reimbursement for the service in question?

Findings

Geneva Medical Management, Inc. is seeking reimbursement for a designated doctor examination as ordered by the DWC.

The submitted documentation supports that Philip Mycoskie, M.D. performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[2]

Review of the submitted documentation finds that Dr. Mycoskie performed impairment rating evaluations of the left shoulder, left hip, and cervicothoracic spine with range of motion testing. The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[3] The MAR for the evaluation of a musculoskeletal body area determined using the DRE method is $150.00.[4] The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each.[5]

Dr. Mycoskie based his determination of impairment of the left shoulder on Figures 38, 41, and 44 on pages 43, 44, and 45, which are in the subchapter for upper extremities of the AMA Guides, Chapter 3.[6]

Dr. Mycoskie based his determination of impairment of the left hip on Figure 40, page 78, which is in the subchapter for lower extremities of the AMA Guides, Chapter 3.

Dr. Mycoskie based his determination impairment of the cervicothoracic spine on Table 73, page 110, which is in the subchapter for the spine of the AMA Guides, Chapter 3.

The total MAR for the determination of impairment rating is $600.00.

The total allowable for the examination in question is $950.00. The insurance carrier reimbursed $800.00. An additional reimbursement of $150.00 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 $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.

[2] 28 TAC §134.250(3)(C)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[4] 28 TAC §134.250(4)(C)(ii)(I)
[5] 28 TAC §134.250(4)(C)(ii)(II)(-b-)
[6] *AMA Guides to the Evaluation of Permanent Impairment,* Fourth Edition

Authorized Signature

		August 25, 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.