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
ARMSTRONG, DANIEL C.

Respondent Name
TRAVELERS INDEMNITY CO

MFDR Tracking Number
M4-20-2732-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
July 20, 2020

REQUESTOR'S POSITION SUMMARY

"99456 W5 WP MMI = $350.00
IR – W/ROM = $300.00
TTL = $650.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

"General range of motion testing was performed as part of the evaluation for Maximum Medical Improvement and extent of injury. The Provider assigned an impairment rating solely under the DRE model."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2020	Designated Doctor Examination (99456-W5-WP)	$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 with the following claim adjustment codes:
   - P12 – The charge for this procedure exceeds the fee schedule allowance.
   - 309 – Reimbursement is based on the applicable reimbursement fee schedule.
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- 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance is payable if a determination of the impairment cased by the compensable injury was also performed.

Issues

Is Daniel C. Armstrong, D.C. entitled to additional reimbursement for the examination in question?

Findings

Dr. Armstrong is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating.

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

The submitted documentation also supports that Dr. Armstrong provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the lumbar spine. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[2]

The total allowable reimbursement for the examination in question is $650.00. The insurance carrier paid $500.00. 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.

Authorized Signature

		August 18, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

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

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.