



# 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

**Requester Name**

DAHM, LIDA S

**Respondent Name**

NORGUARD INSURANCE CO

**MFDR Tracking Number**

M4-20-2747-01

**Carrier's Austin Representative**

Box Number 06

**MFDR Date Received**

July 22, 2020

#### REQUESTER'S POSITION SUMMARY

"These services were requested and prescribed by the Division ... We seek full reimbursement for the outstanding balance of \$650.00 along with interest accrued according to Rule 134.803 ..."

**Amount in Dispute:** \$1,300.00

#### RESPONDENT'S POSITION SUMMARY

Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 19, 2020	Designated Doctor Examination (99456-W5-26 and 99456-W5-TC)	\$1,300.00	\$500.00
March 19, 2020	Designated Doctor Examination (99456-W6-RE)	\$0.00	\$0.00
Total		\$1,300.00	\$500.00

#### 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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 217 – The value of this procedure is included in the value of another procedure performed on this date.

- 97 – The benefit for this service included in the payment/allowance for another service/procedure that has already been adjudicated.
- Notes: “99456 is included in other services, Hence denied 99456 with MM 217. Re-Evaluation may be done upon Submission of sufficient medical records supporting the billed code.”
- Notes: “This is a re-evaluation bill. History bill ... was paid correctly For billed CPT Codes 99456. However, history bill. However, history bill was underpaid due to PPO reduction. Hence, no changes made to the billed PT services and no additional payment made.”
- Notes: “This is a re-evaluation bill. Billed services 99456 in the history bill ... were denied by the system. Re-submitted bill and medical document reviewed. However, billed service 99456 are denied by the system again. Hence, no changes are made and no additional payment is made.”

### **Issues**

1. Did Norguard Insurance Company respond to the medical fee dispute?
2. What are the services reviewed in this dispute?
3. Is Lida S. Dahm, M.D. entitled to additional reimbursement for the services in question?

### **Findings**

1. The Austin carrier representative for Norguard Insurance Company is Stone Loughlin & Swanson, LP. The representative was notified of this medical fee dispute on July 28, 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.<sup>1</sup>

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

2. The submitted documentation lists examinations to determine maximum medical improvement, impairment rating, and extent of the compensable injury for this dispute. Dr. Dahm is seeking \$0.00 for the examination to determine the extent of the compensable injury. Therefore, this examination will not be reviewed in this dispute. The DWC will review the examination to determine maximum medical improvement and impairment rating in this dispute.
3. The submitted documentation supports that Dr. Dahm performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is \$350.00.<sup>2</sup>

Review of the submitted documentation finds that Dr. Dahm performed impairment rating evaluations of the skin, using “the American Medical Association Guides to the Evaluation of Permanent Impairment, 4<sup>th</sup> Edition, 4<sup>th</sup> Printing, October 1999, Chapter 13, The Skin, page 280, Table 2, Impairment Classes and Percents for Skin Disorder.”

The MAR for the assignment of impairment rating for non-musculoskeletal body areas is \$150.00 each.<sup>3</sup> Because the skin is a non-musculoskeletal body area<sup>4</sup> the total MAR for the determination of impairment rating is \$150.00.

The total allowable reimbursement for the services in question is \$500.00. This amount is recommended.

### **Conclusion**

For the reasons stated above, the DWC finds that the requester has established that additional reimbursement is due. As a result, the amount ordered is \$500.00.

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<sup>1</sup> 28 TAC §133.307(d)(1)

<sup>2</sup> 28 TAC §134.250(3)(C)

<sup>3</sup> 28 TAC §134.250(4)(D)(v)

<sup>4</sup> 28 TAC §134.250(4)(D)(i)

**ORDER**

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requester is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requester \$500.00, 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

\_\_\_\_\_  
October 5, 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.**