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
SKLAR, JOHN ANTHONY

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-21-0270-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 14, 2020

REQUESTOR'S POSITION SUMMARY

"Dr. Sklar addressed MMI 350.00 ROM upper extremity $300.00 lower extremity 150.00 head 150.00 vision 150.00 (4 body areas) total $1100.00. See attached for TDI fee schedule for additional certifications. ($50.00)"

Amount in Dispute: $200.00

RESPONDENT'S POSITION SUMMARY

"The provider is seeking additional reimbursement based upon the impairment rating portion of the exam as well as the issuance of multiple certifications. The provider billed a total of $1,650.00 He was reimbursed $1,450.00. He was reimbursed $500 for the extent of injury portion of the exam, and he was reimbursed $950 for the MMI and impairment rating portion of the exam.

… We believe that the provider's position is that he is entitled to $350 for the MMI portion of the exam, that he is entitled to $300 for range of motion of upper extremities, that he is entitled to $150 for the exam of the lower extremities, that he is entitled to $150 for examination of the head and that he is entitled to $150 for the chest area [rib area]. That would total four body areas. The major difference of opinion between the provider and the carrier comes down to range of motion testing. We do not believe that the range of motion testing meets the requisites of a full physical examination with range of motion as required by Rule 134.250 [4][C]."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 18, 2020	Designated Doctor Examination	$200.00	$200.00

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 schedule 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:
   - 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - Notes: "NO ALLOWANCE CHANGE"

Issues

Is John A. Sklar, M.D. entitled to additional reimbursement for the designated doctor examination in question?

Findings

Dr. Sklar is seeking additional reimbursement for a designated doctor examination performed on August 18, 2020.

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

Review of the submitted documentation finds that Dr. Sklar performed impairment rating evaluations of the ribs, head, knee contusion, and wrist with range of motion testing. The MAR for the evaluation of a musculoskeletal body area performed with a full physical examination and 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 assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.[4]

Flahive, Ogden & Latson argued that "We do not believe that the range of motion testing meets the requisites of a full physical examination with range of motion as required by Rule 134.250 [4][C]." The insurance carrier's representative failed to support its claim. Therefore, the total MAR for the determination of impairment rating is $750.00.

The submitted documentation indicates that Dr. Sklar 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. Dr. Sklar billed this service with procedure code 99456 and modifier MI. Therefore, the correct MAR for this service is $50.00.[5]

The total allowed amount for the examination in question is $1,150.00. The insurance carrier paid $950.00. An additional $200.00 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 $200.00.

[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)
[5] 28 TAC §134.250(4)(B)

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 $200.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		December 2, 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.