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
RAMPY, ROBBIE

Respondent Name
IMPERIUM INSURANCE CO

MFDR Tracking Number
M4-21-0794-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 19, 2021

REQUESTOR'S POSITION SUMMARY

"99456 W5 WP MMI = $350.00
IR – KNEE = $300.00
IR – BACK = $150.00
IR – PTSD = $150.00
IR – BUTTOCK CONT = $150.00
TTL = $1100.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

"The Carrier has reimbursed the Provider $600 for the impairment rating portion of the exam plus $350 for the MMI portion of the exam which totals $950. The Provider is seeking an additional $150. It is the Carrier's position that it has reimbursed the Provider all the monies that the Provider is entitled to."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 13, 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:
   - 119 – Benefit maximum for this time period or occurrence has been reached.
   - 186 – Additional charges received, but no additional allowance is recommended due to the maximum allowance or this admission has been reached.
   - 6766 – Specialty Bill Audit/Expert Code Review involving the application of code auditing rules and edits based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT Manual, and coding guidelines dev

Issues

Is Robbie Rampy, M.D. entitled to additional reimbursement?

Findings

Dr. Rampy is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating.

The submitted documentation supports that Dr. Rampy 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. Rampy performed impairment rating evaluations with range of motion testing of the left knee, lumbosacral spine, right buttock contusion, and PTSD. The MAR for the evaluation of a musculoskeletal body area performed with 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] The total MAR for the determination of impairment rating is $750.00.

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement			$350.00
IR: Left Knee (ROM)	Musculoskeletal System	Lower Extremities	$300.00
IR: Lumbar Spine (ROM)		Spine and Pelvis	$150.00
Right Buttock Contusion	Skin	Body Structures	$150.00
IR: Retroperitoneal Hematoma			
IR: PTSD	Mental and Behavioral Disorders	Mental and Behavioral Disorders	$150.00
Total MMI			**$350.00**
Total IR			**$750.00**
Total Exam			**$1,100.00**

The total allowable reimbursement for the services in question is $1,100.00. The insurance carrier paid $950.00. The DWC recommends an additional reimbursement of $150.00.

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.

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[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)

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

		March 5, 2021
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.