



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

HAYES, MARCUS PAUL

Respondent Name

ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number

M4-21-0820-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 20, 2021

REQUESTOR'S POSITION SUMMARY

"In this particular case, Zurich reimbursed AI&FATC for the MMI certification and IR determination for the ankle, **but not for the IR determination for the spine.**"

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

"The initial EOB recommended reimbursement of \$650. The second EOB recommended no additional reimbursement. It remains the Carrier's position that the Provider was entitled to reimbursement of \$650 and that the Provider is not entitled to any additional reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 2, 2020	Designated Doctor Examination (99456-WP x 2)	\$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

- 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:
 - P12 – Workers' compensation jurisdictional fee schedule adjustment.
 - Note: "NO ALLOWANCE CHANGE"

Issues

Is Marcus Hayes, D.C. entitled to additional reimbursement for the examination in question?

Findings

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

The submitted documentation supports that Dr. Hayes performed an evaluation of maximum medical improvement. The maximum allowable reimbursement (MAR) for this examination is \$350.00.¹

Review of the submitted documentation finds that Dr. Hayes performed impairment rating evaluations of the spine and left ankle with range of motion testing. 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 total MAR for the determination of impairment rating is \$450.00.

The total allowable reimbursement for the examination in question is \$800.00. The insurance carrier paid \$650.00. 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

Signature

Medical Fee Dispute Resolution Officer

March 5, 2021
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.

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-)