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
JKB MEDICAL EXAMS

Respondent Name
GRAPEVINE COLLEYVILLE ISD

MFDR Tracking Number
M4-21-0918-01

Carrier's Austin Representative
Box Number 55

MFDR Date Received
February 2, 2021

REQUESTOR'S POSITION SUMMARY

"We billed $900.00 for 5 body parts, and were only paid $300.00."

Amount in Dispute: $600.00

RESPONDENT'S POSITION SUMMARY

"With further review additional monies of 450.00 was determined to be owed to the provider due for total IR of $750.00 (ROM @2-body areas>Upper extremities & Spine-neck=$450.00 and 2-DRE for the body system & body structures of the non-musculoskeletal body areas $300.00) minus of $300.00 of previous payment."

Response Submitted by: Sedgwick

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 5, 2020	Designated Doctor Examination (99456-W5-WP)	$600.00	$0.00

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 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:
   - P5 – Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.

Issues

Is JKB Medical Exams entitled to additional reimbursement?

Findings

JKB Medical Exams is seeking additional reimbursement for determination of an impairment rating as part of a designated doctor examination performed on August 5, 2020.

Review of the submitted documentation finds that James Bales, M.D. performed impairment rating evaluations of the left wrist and cervical spine with range of motion testing, thyroid disease, and Crohn's disease.

The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[1] The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each.[2] The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.[3]

The total MAR for the disputed service is $750.00.

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]		$350.00
IR: Left Wrist (ROM)	Musculoskeletal System	Upper Extremities	$300.00
IR: CRPS			
IR: Cervical Radiculopathy (ROM)		Spine and Pelvis	$150.00
IR: Thyroid Disease	Endocrine System	Body Systems	$150.00
IR: Crohn's Disease	Digestive System	Body Systems	$150.00
Total MMI	[redacted]		**$350.00**
Total IR			**$750.00**
Total Exam			**$1,100.00**

Based on explanations of benefits dated August 10, 2020, and February 9, 2021, the insurance carrier paid $750.00 for the services in dispute. No additional reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 6, 2021 Date

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

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.