



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

QURASHI, RAFATH

Respondent Name

TRANSPORTATION INSURANCE CO

MFDR Tracking Number

M4-21-1263-01

Carrier's Austin Representative

Box Number 57

MFDR Date Received

March 23, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed a total of \$800.00 for MMI/IR Evaluation with CPT code 99456-WP (X2 Unit) on the first line item. The Insurance Carrier CNA paid \$350.00 for the MMI Evaluation, and \$300.00 for IR of the LT Upper Extremity with range of motion, the carrier denied the \$150.00 for additional musculoskeletal body area of the (Spine) ... After speaking to a representative in the bill review department they sent bac the bill to get it reprocessed, and the insurance carrier CAN made an additional payment of \$50.00, leaving a balance of \$100.00 still due."

Amount in Dispute: \$100.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier forwarded to our URA, Conduent, for review. It was determined an additional allowable is indeed owed. Carrier has issued payment ..."

Response Submitted by: Law Office of Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 10, 2020	Examination to Determine Maximum Medical Improvement and Impairment Rating (99456-WP)	\$100.00	\$50.00

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.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 309 – The charge for this procedure exceeds the fee schedule allowance.
 - P12 – Workers’ compensation jurisdictional fee schedule adjustment.
 - W3 – Additional payment made on appeal/reconsideration.
 - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 1014 – The attached billing has been re-evaluated at the request of the provider, based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
 - 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.

Issues

Is Rafath Quraishi, M.D. entitled to additional reimbursement for the examination in question?

Findings

Dr. Quraishi is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating. Based on the submitted information the insurance carrier paid the following amounts:

- \$650.00 on or about November 19, 2020,
- \$50.00 on or about February 28, 2021, and
- \$50.00 on or about May 14, 2021.

The submitted documentation supports that Dr. Quraishi 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. Quraishi performed impairment rating evaluations of the left shoulder with range of motion testing and the spine using the DRE method. 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 a musculoskeletal body area determined using the DRE method is \$150.00.³ The total MAR for the determination of impairment rating is \$450.00.

The total allowable for the examination in question is \$800.00. The insurance carrier paid \$750.00. An additional \$50.00 is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered. For the reasons stated above, the Texas Department of Insurance, Division of Workers’ Compensation (DWC) finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$50.00.

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)(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 requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor \$50.00, 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

June 25, 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 division 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.