



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

QUIROZ, JUAN FRANCISCO

Respondent Name

ZURICH AMERICAN INSURANCE CO

MFDR Tracking Number

M4-21-1384-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

April 7, 2021

REQUESTOR'S POSITION SUMMARY

“ MMI = \$350.00
IR – UPPER EXTREMITY = \$300.00
IR – LOWER EXTREMITY = \$150.00
IR – BACK = \$150.00
IR – SKIN = \$150.00
TTL = \$1100.00”

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

“The provider billed \$350 for the MMI portion of the exam which the carrier is in agreement with. The provider billed for the upper extremity, lower extremity and back. The carrier does not disagree with the reimbursement rate for them either. However, the provider duplicated the billing of the upper extremities, lower extremity and back when the provider included reimbursement for the skin ... It is the carrier's position that they would be included in the \$300 that the provider was already billing for the upper extremities.”

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 1, 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.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers’ compensation jurisdictional fee schedule adjustment.
 - Notes: “NO ALLOWANCE CHANGE”

Issues

Is Juan Quiroz, M.D. entitled to additional reimbursement for the examination in question?

Findings

Dr. Quiroz is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating of the compensable injury.

The submitted documentation supports that Dr. Quiroz performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is \$350.00.¹

Impairment ratings are determined using the *AMA Guides to the Evaluation of Permanent Impairment* (AMA Guides), Fourth Edition.² The fee guidelines for impairment ratings are subject to 28 TAC §134.250(4).

Review of the submitted documentation finds that Dr. Quiroz performed impairment rating evaluations of the following:

- Lumbosacral spine, based on the DRE method;
- Left wrist, using range of motion;
- Left hand, using range of motion;
- Right hand, using range of motion;
- Right forearm, using range of motion;
- Right knee, using range of motion;
- Right ankle, using range of motion;
- Left knee, using range of motion;
- Left ankle, using range of motion; and
- Skin, including scars.

Impairment of the lumbar spine is found in Chapter 3, subchapter 3.3 of the *AMA Guides*, fourth edition. This is the spinal subchapter of the musculoskeletal chapter. The spine is considered one body area in the fee guidelines.³

Impairment of the left wrist, left hand, right hand, and right forearm is found in Chapter 3, subchapter 3.1 of the *AMA Guides*, fourth edition. This is the upper extremities subchapter of the musculoskeletal chapter. The upper extremity is considered one body area in the fee guidelines.⁴

Dr. Quiroz based the impairment rating of the right knee, right ankle, left knee, and left ankle on Chapter 3, subchapter 3.2 of the *AMA Guides*, fourth edition.⁵ This is the lower extremities subchapter of the musculoskeletal chapter. The lower extremity is considered one body area in the fee guidelines.⁶

Dr. Quiroz based the impairment rating of the skin on Chapter 13, table 2, page 280 of the *AMA Guides*, fourth edition.⁷ This chapter relates the to the skin, a body system which is considered one body area in the fee guidelines.⁸

¹ 28 TAC §134.250(3)(C)

² 28 TAC §130.1(c)(2)

³ 28 TAC §134.250(4)(C)(i)(II)

⁴ 28 TAC §134.250(4)(C)(i)(II)

⁵ 28 TAC §134.250(4)(D)(iv)(I)

⁶ 28 TAC §134.250(4)(C)(i)(II)

⁷ 28 TAC §134.250(4)(D)(iv)(I)

⁸ 28 TAC §134.250(4)(D)(i)(II)

The MAR for the evaluation of a musculoskeletal body area performed with range of motion is \$300.00.⁹ The MAR for the evaluation of a musculoskeletal body area determined using the DRE method is \$150.00.¹⁰ The MAR for the evaluation of subsequent musculoskeletal body areas is \$150.00 each.¹¹ The MAR for the assignment of impairment rating for non-musculoskeletal body areas is \$150.00 each.¹²

The total MAR for the determination of impairment rating is \$750.00.

The total allowable reimbursement for the designated doctor examination in question is \$1,100.00. The insurance carrier reimbursed \$950.00. An additional reimbursement of \$150.00 is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. 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

_____	_____	June 9, 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.

⁹ 28 TAC §134.250(4)(C)(ii)(II)(-a-)

¹⁰ 28 TAC §134.250(4)(C)(ii)(I)

¹¹ 28 TAC §134.250(4)(C)(ii)(II)(-b-)

¹² 28 TAC §134.250(4)(D)(v)