TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
PACIFIC BILLING

**Respondent Name**
AMERICAN ZURICH INSURANCE CO

**MFDR Tracking Number**
M4-21-1762-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
June 2, 2021

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "MMI = $350.00
IR – LOWER EXTREMITY = $300.00
IR – CONTUSION = $150.00
TTL = $800.00"

**Amount in Dispute:** $150.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The provider conducted an MMI and impairment rating evaluation. He was reimbursed $350 for the MMI portion of the exam and $300 for the range of motion portion of the exam … the provider identified two diagnosis during the provider's exam as follows: 1) [redacted]; 2) [redacted].

We believe that the provider is billing $500 between those two diagnoses yet, both diagnosis were to the same body area. Reimbursement is based upon the body area. The total reimbursement would not exceed $300 for the assignment of the impairment rating."

**Response Submitted by:** Flahive, Ogden & Latson

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| September 16, 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:
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 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.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3 – Additional payment made on appeal/reconsideration.

**Issues**

Is Pacific Billing entitled to additional reimbursement for the examination in question?

**Findings**

Pacific Billing 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. Robbie Rampy, M.D. 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. Rampy performed impairment rating evaluations of a contusion to the left knee and a left fibular fracture using range of motion testing.

Impairment ratings of lower extremities are based on Chapter 3, subchapter 3.2 of the *AMA Guides,* fourth edition.[3] This is the lower extremities subchapter of the musculoskeletal chapter. The lower extremity is considered one body area in the fee guidelines.[4]

Dr. Rampy based the impairment rating of the skin on Chapter 13, table 2, page 280 of the *AMA Guides,* fourth edition.[5] This chapter relates the to the skin, a body system which is considered one body area in the fee guidelines.[6]

The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[7] The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.[8]

The total MAR for the determination of impairment rating is $450.00.

The total allowable reimbursement for the designated doctor examination in question is $800.00. The insurance carrier reimbursed $650.00. An additional reimbursement of $150.00 is recommended.

[1] 28 TAC §134.250(3)(C)
[2] 28 TAC §130.1(c)(2)
[3] 28 TAC §134.250(4)(D)(iv)(I)
[4] 28 TAC §134.250(4)(C)(i)(II)
[5] 28 TAC §134.250(4)(D)(iv)(I)
[6] 28 TAC §134.250(4)(D)(i)(II)
[7] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[8] 28 TAC §134.250(4)(D)(v)

**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 $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**

| | | |
|---|---|---|
| | | July 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**.