

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Michael Leonard, M.D.

Respondent Name

Bitco National Insurance Co.

MFDR Tracking Number

M4-21-2002-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 12, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 1, 2020	Designated Doctor Examination (99456-W5-WP)	\$150.00	\$0.00

Requestor's Position

"DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION ... The attached claim was billed based on DWC **Rule 134.204 (i) (4) (C) (ii)** regarding Designated Doctor Examinations as it applies it applies for billing and reimbursement of an IR (Impairment Rating) evaluation. Range of motion was necessary and performed as part of a full evaluation performed for the billed examination."

Amount in Dispute: \$150.00

Respondent's Position

"CorVel maintains, the requestor Michael Martin Leonard, MD is entitled to \$0.00 additional reimbursement for the medical disability examination performed on 09/01/20 to address Impairment (MMI/IR) based on failure to submit appropriate documentation to substantiate services billed in accordance with workers' compensation specific services outlined under 28 TAC Chapter 134."

Response Submitted by: CorVel

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' Compensation State Fee Schedule Adj
- ORC – See Additional Information
- Notes: "DOCUMENTATION THAT DRE METHOD WAS USED FOR IMPAIRMENT RATING, NO ROM TESTING IS DOCUMENTED. NO ADD'L DUE."
- Notes: "MMI/DD/DRE/3 BODY AREAS (SCALP CONTUSION, BACK (LOWER AND UPPER), CONCUSSION 3 AREAS X \$150.00 IS \$450.00 + \$350.00 = \$800.00"

Issues

1. Is Michael Leonard, M.D. entitled to additional reimbursement?

Findings

1. Dr. Leonard is seeking additional reimbursement for a designated doctor examination that included an evaluation of maximum medical improvement and impairment rating.

The submitted documentation supports that Dr. Leonard performed an evaluation of maximum medical improvement as ordered by the DWC. 28 TAC §134.250 (3)(C) states that the maximum allowable reimbursement (MAR) for this examination is \$350.00.

Review of the submitted documentation finds that Dr. Leonard performed impairment rating evaluations of the spine using the DRE method, a scalp contusion, traumatic headache, and a concussion. Documentation submitted to DWC provides no evidence that range of motion testing was performed.

The rule at 28 TAC §134.250 (4)(C) defines the fees for the calculation of an impairment rating. The MAR for the evaluation of a musculoskeletal body area determined using the DRE method is \$150.00. The MAR for the assignment of impairment rating for non-musculoskeletal body areas is \$150.00 each. The total MAR for the determination of

impairment rating is \$450.00.

The total allowable reimbursement for the examination in question is \$800.00. Per explanation of benefits dated January 19, 2021, this is the amount paid by the insurance carrier for the service in question. DWC concludes that Dr. Leonard is not entitled to additional reimbursement.

Conclusion

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

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

_____	_____	September 15, 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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.