TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Jan Petrasek, M.D.

Respondent Name
Bridgefield Casualty Insurance

MFDR Tracking Number
M4-21-2016-01

Carrier's Austin Representative
Box Number 17

DWC Date Received
July 12, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 12, 2020	Designated Doctor Examination (99456-W5-WP)	$300.00	$0.00

Requestor's Position

"DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION"

Amount in Dispute: $300.00

Respondent's Position

"With regard to the reimbursement amount for the impairment rating, DWC Rule 134.250(4), has two different methods: $150.00 if the diagnosis related estimates (DRE) method is used; and $300.00 if full physical evaluation and range of motion is performed. A review of the report from Requestor shows range of motion testing was not completed. Further, Requestor assigned an impairment rating to the Claimant based on the lumbar DRE Category I. Therefore, Requestor is owed an additional $150.00 for the impairment rating examination. Respondent allowed reimbursement in this amount on the attached EOB."

Response Submitted by: Downs-Stanford, P.C.

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 jurisdictional fee schedule adjustment. This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
- Notes: "AFTER FURTHER REVIEW, NO BALANCE DUE"

Issues

1. Is Jan Petrasek, M.D. entitled to additional reimbursement?

Findings

1. Dr. Petrasek is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating.

   The submitted documentation supports that Dr. Petrasek performed an evaluation of maximum medical improvement. 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. Petrasek used the DRE method to assign an impairment rating evaluation of the lumbar spine. 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 total allowable reimbursement for the services in question is $500.00. Per explanations of benefits dated October 21, 2020, and July 21, 2021, the insurance carrier paid this amount. No additional reimbursement is recommended.

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

Signature	Medical Fee Dispute Resolution Officer	October 11, 2021 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 electronico CompConnection@tdi.texas.gov.