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
J. Scott Harris

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-22-0042-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
September 13, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 27, 2021	99456 (W5, WP)	$1,100.,00	$800.00
	Total	$1,100.00	$800.00

Requestor's Position

This insurance carrier and adjuster have continuously refused to process our billing and forward payment to the address indicated in box 33 of our HCFA claim form.

Amount in Dispute: $1,100.00

Respondent's Position

Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bills in question for manual review to determine if additional monies are owed.

Response submitted by: Gallagher Bassett

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.

3. 28 TAC §134.240 sets out the billing requirements of designated doctor examinations.

Denial Reasons

Neither party submitted an explanation of benefits for the disputed services.

Issues

1. What rule(s) are applicable to disputed service?

Findings

1. The requestor is seeking reimbursement of designated doctor exam with maximum medical improvement and impairment rating.

   When the examining doctor calculates an impairment rating, 28 TAC §§134.250 (4)(A) and 134.240 (1)(A) require the doctor to bill with CPT code 99456 and modifier "W5." The reimbursement shall be $350.00

   When the examining doctor also performs the testing for impairment rating of musculoskeletal body areas, 28 TAC §134.250 (4)(C)(iii) requires the examining doctor to add modifier "WP." The documentation contained a copy of the submitted medical claim that included Code 99456, W5, WP. The requestor met the requirements of applicable rules.

   Review of the submitted documentation finds that Dr. J. S. Harris performed impairment rating evaluations of upper extremities, and lower extremities with range of motion testing.

   DWC Rule 28 TAC §134.250 (4)(C) for musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

   (i) Musculoskeletal body areas are defined as follows:

   (I) spine and pelvis;

   (II) upper extremities and hands; and

   (III) lower extremities (including feet).

The documentation supports three musculoskeletal body areas were evaluated.

The rule at 28 TAC §134.250 (4)(C) defines the fees for the calculation of an impairment rating for musculoskeletal body areas.

The MAR for the evaluation of the first musculoskeletal body area performed with range of motion is $300.00.

The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each.

The total MAR for the disputed date of service January 27, 2021, is $350.00 (examination) plus $300.00 (first musculoskeletal body area/upper extremity) plus $150.00 (second musculoskeletal body area/lower extremity) a total of $800.00. This amount 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 established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Zurich American Insurance Co must remit to J. Scott Harris $800.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

		January 11, 2022
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 electronico CompConnection@tdi.texas.gov.