TDI Division of Workers' Compensation
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Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Gary Williams, M.D.

Respondent Name
Phoenix Insurance Company

MFDR Tracking Number
M4-22-0223-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
October 5, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 16, 2021	Designated Doctor Examination (99456-W5-WP)	$250.00	$0.00
April 16, 2021	Specialist Report (99456-SP)	$50.00	$0.00
	Total	$300.00	$0.00

Requestor's Position

"DOCTOR DEEMED 6 AREAS AS COMPENSABLE TO DETERMINE IMPAIRMENT RATINGS. HEAD CONCUSSION $300, RIB FRACTURE $150, LUNGS PNEUMOTHORAX $150, RIGHT FOREARM FRACTURE $150, CERVICAL/THORACIC SPINE FRACTURE $150."

Amount in Dispute: $300.00

Respondent's Position

"The Provider contends they are entitled to additional reimbursement of $300.00 for the IR evaluation for the concussion, $150.00 for the IR evaluation of the rib fracture, $150.00 for the IR evaluation of the lung and pneumothorax, $150.00 for the IR evaluation of the right arm fracture, and $150.00 for the IR evaluation of the cervical/thoracic spine fracture. Additionally, although the Provider contends in the Table of Disputed Services that CPT code 99456-SP was not reimbursed, it was in fact reimbursed at $50.00 as documented by the original Explanation of

Benefits attached … The Carrier contends no additional reimbursement is due as the Provider was not properly reimbursed."

Response Submitted by: Travelers

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:

- 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 863 – Reimbursement is based on the applicable reimbursement fee schedule.
- T13 – Medical necessity denial. You may submit a request for an appeal/ reconsideration no later than 10 months from the date of service.
- W3 – No additional reimbursement allowed after review of appeal/reconsideration/ request for second review.
- 8765 – No reimbursement made based on rule 133.250 (b) reconsideration for payment of medical bills. The Health care provider shall submit the request for reconsideration no later than 10 months from the date of service.
- 947 – Upheld. No additional allowance has been recommended.

Issues

1. Is Phoenix Insurance Company's denial based on submission or billing errors supported?

2. Is Phoenix Insurance Company's denial based on medical necessity supported?

3. Is Gary Williams, M.D. entitled to additional reimbursement?

Findings

1. Dr. Williams is seeking additional reimbursement for a designated doctor examination to

determine maximum medical improvement and impairment rating. Phoenix Insurance Company reduced the fees, in part, based on submission or billing errors. Review of the provided documentation does not support this denial reason.

2. Phoenix Insurance Company also reduced the services in question based on medical necessity. The examination was a designated doctor evaluation ordered by DWC. This examination is not subject to denial based on medical necessity.

3. The submitted documentation supports that Dr. Williams 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. Williams performed impairment rating evaluations of the right upper extremity with range of motion testing, the cervical and thoracic spine, a head injury, rib fractures, and mild pneumothorax right upper lobe.

   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 rule at 28 TAC §134.250 (4)(D) defines the fees for the calculation of an impairment rating for non-musculoskeletal body areas. The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.

   Dr. Williams referred the injured employee to a specialist to provide a report to aid in determining the impairment rating for the head injury. The use of this report is noted in the narrative. Per 28 TAC §134.250 (4)(D)(iii), the correct MAR for this service is $50.00.

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]		$350.00
IR: Right Upper Extremity (ROM)	Musculoskeletal System	Upper Extremities	$300.00
IR: Spine (DRE)		Spine and Pelvis	$150.00
IR: Head Injury	Nervous System	Body Systems	$150.00
IR: Lung	Respiratory System	Body Systems	$150.00
IR: Ribs			
Total MMI	[redacted]		**$350.00**
Total IR			**$750.00**
Specialist Report			**$50.00**
Total Exam			**$1,150.00**

   The total allowable reimbursement of the services in question is $1,150.00. Per explanation of benefits dated July 16, 2021, Phoenix Insurance Company paid this amount in full. 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	November 12, 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.