



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Crystal Hogan, D.C.

Respondent Name

Pacific Indemnity Co.

MFDR Tracking Number

M4-22-0817-01

Carrier's Austin Representative

Box Number 17

DWC Date Received

January 3, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
September 7, 2021	Designated Doctor Examination 99456-W5-MI	\$50.00	\$0.00

Requestor's Position

99456 W5 MI PAYS \$50.00 PER UNIT

Amount in Dispute: \$50.00

Respondent's Position

Under the facts of this case, Crystal Hogan, DC provided a DWC-69 for the compensable diagnosis code(s), of which she opined Claimant with MMI on 05/06/21 and a 5% impairment rating. Reimbursement for CPT code 99456 (-W5) was, issued per the division fee guideline for workers' compensation specific services. A "Certification #2" DWC-69 was, submitted to address outstanding extent of injury questions, of which Crystal Hogan, DC opined claimant had not reached MMI. Therefore, an impairment rating was not calculated.

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 denied the payment for the disputed services with the following claim adjustment codes:

- 234 – This procedure is not paid separately.

Issues

1. Is Crystal Hogan, D.C. entitled to additional reimbursement?

Findings

1. Dr. Hogan is seeking additional reimbursement for multiple impairments provided for a designated doctor examination dated September 7, 2021.

The submitted documentation indicates that Dr. Hogan was asked to address maximum medical improvement, impairment rating, and extent of injury. When multiple impairment ratings are required as a component of a designated doctor examination, 28 TAC §134.250 (4)(B) states that the designated doctor shall be reimbursed \$50.00 for each additional impairment rating calculation.

Documentation does not support that the designated doctor provided additional impairment ratings. Therefore, a charge for additional impairment calculations was not supported. DWC does not recommend additional reimbursement for this charge.

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

_____	_____	February 1, 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 electrónico CompConnection@tdi.texas.gov.