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
Cody D. Mead, D.O.

Respondent Name
Service Lloyds Insurance Company

MFDR Tracking Number
M4-22-1119-01

Carrier's Austin Representative
Box Number 01

DWC Date Received
February 10, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 6, 2021	Required Medical Examination 99456-WP	$150.00	$150.00
July 6, 2021	Required Medical Examination 99456-WP	$0.00	$0.00
	Total	$150.00	$150.00

Requestor's Position

A Post-DD RME was performed on July 6, 2021, by Cody D Mead, D.O. … Per the DWC022, Dr. Mead was asked to address **Maximum Medical Improvement and Impairment Rating**. Dr. Mead addressed 1 body area using Diagnosis Related Estimates (DRE), and 2 body areas using the Range of Motion (ROM) method. We were paid for all portions of the exam except the DRE exam portion.

Amount in Dispute: $150.00

Respondent's Position

The previous review is being maintained (Payment of $800.00) and no additional allowance is recommended as the Pyament Adjustor Factor was applied in accordance with the DWC guidelines.

Response Submitted by: Mitchell International, Inc.

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 Texas Administrative Code §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:

- 375 – Please see special *note* below.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- Note: "DISABILITY EXAM MAR $350
ROM LOWER EXTREMITY MAR $300
ROM UPPER EXTREMITY MAR $150"

Issues

1. Is Cody D. Mead, D.O. entitled to additional reimbursement?

Findings

1. Dr. Mead is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating requested by the insurance carrier and ordered by DWC.

   The submitted documentation supports that Dr. Mead 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. Mead performed impairment rating evaluations of the lumbar spine, upper extremities, and lower extremities with range of motion testing.

   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 a musculoskeletal body area determined using the DRE method is $150.00. The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each. The total MAR for the determination of impairment rating is $600.00.

The total allowable reimbursement for the examination in question is $950.00. The insurance carrier paid $800.00. An additional reimbursement of $150.00 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 of $150.00 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 Service Lloyds Insurance Company must remit to Cody D. Mead, D.O. $150.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 18, 2022 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.