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

General Information

Requestor Name
James Edwards, D.C.

Respondent Name
Work First Casualty Co.

MFDR Tracking Number
M4-22-2548-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
August 3, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
December 29, 2021	Designated Doctor Examination 99456-W5-WP	$650.00	$300.00

Requestor's Position

AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED. THE CURRENT RULES ALLOW REIMBURSEMENT.

Subsequent Position: The amount billed and owed was $650. This check is only for $350. $300 remains due.

Amount in Dispute: $650.00

Respondent's Position

Payment has been made for $350.00. We have attached the EOB.

Response Submitted by: Broadspire

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:

- BT100: Unless otherwise specified, services have been reviewed to the State Fee Schedule.
- TXP12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is James Edwards, D.C. entitled to additional reimbursement?

Findings

1. Dr. Edwards is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating.

   The submitted documentation supports that Dr. Edwards performed an evaluation of maximum medical improvement as ordered by DWC. 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. Edwards performed impairment rating evaluations of the right ring finger with range of motion testing. The rule at 28 TAC §134.250 (4)(C)(ii) 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 total allowable reimbursement for the services in question is $650.00. Per explanation of benefits dated August 10, 2022, the insurance carrier paid $350.00. An additional reimbursement of $300.00 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 $300.00 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 Work First Casualty Co. must remit to James Edwards, D.C. $300.00 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	December 1, 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.