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

General Information

Requestor Name
Andrew R. Garcia, D.C.

Respondent Name
Travelers Casualty & Surety Co.

MFDR Tracking Number
M4-23-0072-01

Carrier's Austin Representative
Box Number 05

DWC Date Received
September 7, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 9, 2022	Designated Doctor Examination 99456-W5-WP	$150.00	$0.00

Requestor's Position

The total charge of $950.00 is eligible for reimbursement as originally billed as follows using 99456-W5WP for 3 regions.

$350.00 – Exam by Designated Doctor (It was determined that Mr. Chapas as at MMI.)
$300.00 – Impairment Rating – left arm
$150.00 – Impairment Rating – right arm
$150.00 – Impairment Rating – spine
$950.00 Total billed

Amount in Dispute: $150.00

Respondent's Position

The Provider billed $950 for the exam. The Carrier issued reimbursement of $800 based on the MMI evaluation ($350), the DRE evaluation of the spine ($150), and the range of motion evaluation of the upper extremities ($300). In their position statement, the Provider contends they are entitled to separate reimbursement for the left and right upper extremities, with $300

for the first musculoskeletal body area (the left arm) and $150 for the second musculoskeletal body are (the right arm). Per Rule 134.250(4)(C)(i)(II), the upper extremities and hands together constitute one musculoskeletal body area. Reimbursement for this area under the first range of motion evaluation is $300. The Carrier contends the reimbursement has been calculated correctly.

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 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:

- 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.
- 18 – Exact duplicate claim/service.
- 247 – A payment or denial has already been recommended for this service.
- DUPL – These services have already been considered for reimbursement.

Issues

1. Is Andrew R. Garcia, D.C. entitled to additional reimbursement?

Findings

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

   The submitted documentation supports that Dr. Garcia 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. Garcia performed impairment rating

evaluations of the upper extremities with range of motion testing and the spine. Per 28 TAC §134.250 (4)(C) the spine and pelvis is defined as one body area. Upper extremities and hands are also defined as one body area.

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 MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each. The total MAR for the determination of impairment rating is $450.00.

The total allowable reimbursement for the examination in question is $800.00. The insurance carrier reimbursed this amount. 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

		October 27, 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.