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

General Information

Requestor Name
Donald G. Eaves, D.C.

Respondent Name
Deep East Texas Self Insurance

MFDR Tracking Number
M4-24-0538-01

Carrier's Austin Representative
Box Number 44

DWC Date Received
November 3, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 11, 2023	Designated Doctor Examination 99456-W5-WP	$300.00	$0.00

Requestor's Position

"In my report I addressed maximum medical improvement and impairment rating the spine based on the abdominal strain and range of motion testing for the lumbar spine region. I am requesting reimbursement for the spinal component to be paid at $800 …

"There is no language found in the rule stating if full physical examination, with range of motion, is performed, reimbursement for use of the diagnosis related estimates for determining impairment rating in addition to the charge for the range of motion study is not allowed. There is no language stating either diagnoses related estimates OR physical examination with range of motion is reimbursed."

Amount in Dispute: $300.00

Respondent's Position

"Based on a review of the submitted documentation a recommendation is being made for the amount of $150.00 including interest … The provider billed and the exam indicates one body

area. The ROM method was used to determine the IR. Fee Schedule for the exam would be $350.00 MMI, $300.00 IR and $500.00 RTW. Therefore an additional $150.00 is owed for this date of service."

Response Submitted by: Injury Management Organization, Inc.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (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:

- P12 – Workers compensation jurisdictional fee schedule adjustment.

Issues

1. Is Donald G. Eaves, D.C. entitled to additional reimbursement?

Findings

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

   The submitted documentation supports that Dr. Eaves performed an evaluation of maximum medical improvement as ordered by the 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. Eaves performed an impairment rating evaluation of the lumbar spine with range of motion testing. 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 explanations of benefits dated June 15, 2023, and November 14, 2023, the insurance carrier 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 requestor has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 9, 2024
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 three 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 tres o correo electronico CompConnection@tdi.texas.gov.