TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
JKB Medical Exams

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-19-4906-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
July 17, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We billed four body parts and paid for only two."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment of $600.00 was made for Impairment Rating (ROM testing)"

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 10, 2019	Designated Doctor Examination	$150.00	$150.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §127.10 sets out the guidelines for designated doctor examinations.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

Issues

Is the requestor entitled to additional reimbursement for the services in question?

Findings

JKB Medical Exams is seeking an additional reimbursement of $150.00 for a designated doctor evaluation of impairment rating as part of an examination to determine maximum medical improvement, impairment rating, and extent of injury. The designated doctor is directed to bill for the number of body areas rated.[1]

Review of the submitted documentation finds that Dr. James Bales provided impairment ratings of left rib 4-9 fracture, right hand, left upper thigh hematoma, and elevated blood pressure. The maximum allowable reimbursement (MAR) for the evaluation of the right hand, a musculoskeletal body area performed with range of motion is $300.00.[2] The MAR for the evaluation of the left rib fractures, left upper thigh hematoma, and elevated blood pressure, non-musculoskeletal body areas, is $150.00 each, for a total of $450.00.[3] The total MAR for the determination of impairment rating is $750.00.

The total allowable for the evaluation of impairment rating is $750.00. The insurance carrier paid $600.00. An additional reimbursement of $150.00 is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	October 23, 2019
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 in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

[1] 28 TAC §127.10; 28 TAC §134.250
[2] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[3] 28 TAC §134.250(4)(D)(v)