



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Kasey Kunkel, D.C.

**Respondent Name**

Standard Fire Insurance Co.

**MFDR Tracking Number**

M4-24-1043-01

**Carrier's Austin Representative**

Box Number 05

**DWC Date Received**

January 15, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 27, 2023	Designated Doctor Examination 99456-W5-WP	\$150.00	\$0.00

### Requestor's Position

" MMI = 350.00  
 Spine (ROM) = 300.00  
 UE = 150.00  
 Contusion/skin = 150.00  
 LE = 150.00  
 Total = 1100.00"

**Amount in Dispute:** \$150.00

### Respondent's Position

"The Provider contends they are entitled to additional reimbursement for the evaluation. The Carrier has reviewed the reimbursement and contends the Provider has been properly reimbursed. The Carrier reimbursed \$350 for the Maximum Medical Improvement evaluation, \$300 for the first range of motion evaluation of the spine, \$150 for the second range of motion evaluation of the upper extremities, and a second \$150 for the range of motion evaluation of the

lower extremities. Total reimbursement of \$950 is correct for the evaluation documented. Although the Provider contends, they are entitled to an additional \$1509 for evaluation of the 'contusion/skin', no impairment rating evaluation was performed and no rating was given for any contusion or skin injury."

**Response Submitted by:** Travelers

## **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.
- 863 – Reimbursement is based on the applicable reimbursement fee schedule.
- 309 – The charge for this procedure exceeds the fee schedule allowance.

### Issues

1. Is Kasey Kunkel, D.C. entitled to additional reimbursement?

### Findings

1. Dr. Kunkel is seeking additional reimbursement for a designated doctor examination performed on July 27, 2023.

The submitted documentation supports the claim that Dr. Kunkel 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. Kunkel performed impairment rating evaluations of the upper extremities, lower extremities, and 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 MAR for the evaluation of subsequent

musculoskeletal body areas is \$150.00 each.

While Dr. Kunkel is seeking an additional reimbursement for an impairment rating evaluation of contusions, no evidence was provided to support that an impairment was calculated for the skin. The total MAR for the impairment rating evaluations is \$600.00.

The total allowable reimbursement for the services in question is \$950.00. Per explanation of benefits dated August 11, 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**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

March 28, 2024  
\_\_\_\_\_  
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](http://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](mailto: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 electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).