



AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

General Information

Requestor Name

Kevin Prentice, D.C.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-24-1046

Carrier's Austin Representative

Box Number 54

DWC Date Received

January 16, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 20, 2023	Designated Doctor Examination 99456-W5-WP	\$150.00	\$150.00

Requestor's Position

Position Statement: "MMI = 350.00

SPINE ROM = 300.00

LE = 150.00

SKIN = 150.00

TOTAL = 950.00"

Amount in Dispute: \$150.00

Respondent's Position

"In accordance the health care provider was reimbursed as follows for the disability exam:

"MMI/IR Base \$350 + \$300 ROM Lower Extremities + \$150 Spine DRE for a total of \$800. There is no accepted injury to the skin, therefore we have denied that body area."

Response Submitted by: Texas Mutual Insurance Company

Findings and Decision

Authority

By Official Order Number 2024-8468 dated January 12, 2024, the undersigned has been delegated authority by the Commissioner to **amend** fee dispute decisions.

This **amended** findings and decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

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 \(TAC\) §127.10](#) sets out the procedures for designated doctor examinations.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [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:

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- CAC-243 – Services not authorized by network/primary care providers.
- D27 – Provider not approved to treat WorkWell, TX Network claimant.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
- Notes: "892-3 UNITS BILLED, PER DWC RULES 134.204 & 134.250, 2 UNITS REIMBURSED PER THE BODY AREAS RATED. 2 UNITS ALLOWED; 1 UNIT DENIED."
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- DC4 – No additional reimbursement allowed after reconsideration.

Issues

1. Is Kevin Prentice, D.C. entitled to additional reimbursement?

Findings

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

28 TAC §127.10(b) states, "Requirement to review information. Before examining an injured employee, the designated doctor must review the injured employee's medical records, including any analysis of the injured employee's medical condition, functional abilities, and return to work opportunities that the insurance carrier and treating doctor provide in accordance with subsection (a) of this section, and any materials the division submits to the doctor.

- (1) The designated doctor must also review the injured employee's medical condition, history, and any medical records the injured employee provides and must perform a complete physical examination of the injured employee.
- (2) The designated doctor must give the medical records reviewed the weight the designated doctor determines to be appropriate."

The submitted documentation supports that Dr. Prentice performed an evaluation of maximum medical improvement (MMI) 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. Prentice performed impairment rating evaluations of the (redacted) with range of motion testing, and (redacted). 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.

28 TAC §134.250(4)(D) defines the fees for the calculation of an impairment rating for non-musculoskeletal body areas. The MAR for the assignment of impairment rating for non-musculoskeletal body areas is \$150.00 each.

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement			\$350.00
IR: (redacted)	Musculoskeletal System	Spine and Pelvis	\$300.00
IR: (redacted)		Lower Extremities	\$150.00
IR: (redacted)	Skin	Body Structures (includ	\$150.00
IR: (redacted)			
Total MMI			\$350.00
Total IR			\$600.00
Total Exam			\$950.00

The DWC finds that the total allowable reimbursement for the services in question is \$950.00. The insurance carrier paid \$800.00. An additional reimbursement of \$150.00 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 requestor has established that additional reimbursement of \$150.00 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 Texas Mutual Insurance Company must remit to Kevin Prentice, D.C. \$150.00 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

March 7, 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. 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 electrónico CompConnection@tdi.texas.gov.