TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**
Kevin McAlpin, D.C.

**Respondent Name**
American Zurich Insurance Co.

**MFDR Tracking Number**
M4-24-1055-01

**Carrier's Austin Representative**
Box Number 19

**DWC Date Received**
January 16, 2024

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| March 30, 2023 | Designated Doctor Examination 99456-W5-WP | $650.00 | $650.00 |
| | Designated Doctor Examination 99456-W5-MI | $50.00 | $50.00 |
| | Designated Doctor Examination 99456-W6-RE | $500.00 | $500.00 |
| | Designated Doctor Examination 99456-W8-RE | $250.00 | $250.00 |
| | **Total** | $1,450.00 | $1,450.00 |

## Requestor's Position

"AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED; THE CURRENT RULES ALLOW REIMBURSEMENT."

**Amount in Dispute:** $1,450.00

## Respondent's Position

The Austin carrier representative for American Zurich Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on January 23, 2024.

Per 28 Texas Administrative Code §133.307 (d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

## 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 (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.235 sets out the fee guidelines for examinations to determine extent of injury, return to work, and disability.
3. 28 TAC §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
4. 28 TAC §134.240 sets out medical fee guidelines for designated doctor examinations.
5. Texas Labor Code (TLC) §408.0041 sets out provisions of Designated Doctor examinations under the Texas Workers' Compensation Act.

Denial Reasons

- 165 - PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED REFERRAL.
- D48 - PAYMENT DENIED/REDUCED FOR ABSENCE OF, OR EXCEEDED REFERRAL.
- P12 - WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.
- 790 - THIS CHARGE WAS REIMBURSED IN ACCORDANCE WITH THE TEXAS MEDICAL FEE GUIDELINE.

Issues

1. What rules apply to the services in dispute?
2. Is the insurance carrier's reason for denial supported?
3. Is the requestor entitled to reimbursement?

Findings

1. This medical fee dispute involves an examination by a designated doctor for the purpose of establishing if maximum medical improvement (MMI) has been reached; establishing what date MMI was reached if applicable; to provide impairment ratings (IR) if MMI has been reached; and to address extent of injury and disability.

   Designated Doctor examinations are addressed under Texas Labor Code (TLC) §408.0041. TLC §408.0041 states in pertinent part, "DESIGNATED DOCTOR EXAMINATION.

   (a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:
   (1) the impairment caused by the compensable injury;
   (2) the attainment of maximum medical improvement;
   (3) the extent of the employee's compensable injury;
   (4) whether the injured employee's disability is a direct result of the work-related injury;
   (5) the ability of the employee to return to work; or
   (6) issues similar to those described by Subdivisions (1)-(5) …

   (h) The insurance carrier shall pay for:
   (1) an examination required under Subsection (a), (f), or (f-2), unless otherwise prohibited by this subtitle or by an order or rule of the commissioner;"

   DWC finds that 28 TAC §134.250 applies to the billing and reimbursement of the designated doctor services in dispute. 28 TAC §134.250, which sets out the fee guidelines for maximum medical improvement examinations and impairment ratings, states in pertinent part, "(3) The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT code 99456. Reimbursement shall be $350. (4) The following applies for billing and reimbursement of an IR evaluation. (A) The health care provider shall include billing components of the IR evaluation with the applicable MMI evaluation CPT code. The number of body areas rated shall be indicated in the unit's column of the billing form. (B) When multiple IRs are required as a component of a designated doctor examination under this title, the designated doctor shall bill for the number of body areas rated and be reimbursed $50 for each additional IR calculation. Modifier "MI" shall be added to the MMI evaluation CPT code. (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
   (i) Musculoskeletal body areas are defined as follows:
   (I) spine and pelvis;
   (II) upper extremities and hands; and
   (III) lower extremities (including feet).
   (ii) The maximum allowable reimbursement (MAR) for musculoskeletal body areas shall be as follows:
   (I) $150 for each body area if the diagnosis related estimates (DRE) method found in the AMA Guides fourth edition is used.
   (II) If full physical evaluation, with range of motion, is performed: (-a-) $300 for the first musculoskeletal body area; and (-b-) $150 for each additional musculoskeletal body

area.

(iii) If the examining doctor performs the MMI examination and the IR testing of the musculoskeletal body area(s), the examining doctor shall bill using the appropriate MMI CPT code with modifier 'WP.' Reimbursement shall be 100 percent of the total MAR…"

28 TAC §134.235, which also applies to the billing and reimbursement of the services in dispute, states, "The following shall apply to return to work (RTW)/evaluation of medical care (EMC) examinations. When conducting a division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT code 99456 with modifier 'RE.' In either instance of whether maximum medical improvement/ impairment rating (MMI/IR) is performed or not, the reimbursement shall be $500 in accordance with §134.240 of this title and shall include division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee."

DWC finds that 28 TAC §134.240 applies to the services in dispute and states "The following shall apply to designated doctor examinations:

(1) Designated doctors shall perform examinations in accordance with Labor Code §§408.004, 408.0041, and 408.151 and division rules, and shall be billed and reimbursed as follows:

(A) Impairment caused by the compensable injury shall be billed and reimbursed in accordance with §134.250 of this title, and the use of the additional modifier 'W5' is the first modifier to be applied when performed by a designated doctor;

(B) Attainment of maximum medical improvement shall be billed and reimbursed in accordance with §134.250 of this title, and the use of the additional modifier 'W5' is the first modifier to be applied when performed by a designated doctor;

(C) Extent of the employee's compensable injury shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier 'W6'.

(D) Whether the injured employee's disability is a direct result of the work-related injury shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier 'W7'.

(E) Ability of the employee to return to work shall be billed and reimbursed in accordance with §134.235 of this title, with the use of the additional modifier 'W8'…"

2. A review of the submitted explanation of benefits (EOB) finds that the insurance carrier denied the services in dispute based on absence of a referral or the referral was exceeded.

   A review of the submitted documentation and information known to DWC, finds a Commissioner's Order for a Designated Doctor Exam dated March 13, 2023, for the disputed examination, which was rendered on March 30, 2023, by Kevin McAlpin, D.C.

   Per the documentation reviewed, the designated doctor examination in dispute was ordered by the commission in accordance with TLC §408.0041 and does not require a referral. Therefore, DWC finds that the insurance carrier's reason for denial is not supported.

3. Because the insurance carrier's reason for denial of the disputed services is not supported, DWC finds that the designated doctor, Kevin McAlpin, D.C., is entitled to reimbursement.

   The submitted documentation supports that Kevin McAlpin, D.C., performed an evaluation of maximum medical improvement as ordered by DWC. Per 28 TAC §134.250 (3)(C) the maximum allowable reimbursement (MAR) for this examination is $350.00.

   A review of the submitted documentation finds that Kevin McAlpin, D.C., performed impairment rating evaluations of the right lower extremity with range of motion testing. 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.

   Documentation known to DWC indicates that Kevin McAlpin, D.C., was ordered to address maximum medical improvement, impairment rating, disability, and extent of injury. The narrative report and enclosed forms support that these evaluations were performed, and one additional impairment rating was provided. When multiple impairment ratings are required as a component of a designated doctor examination, 28 TAC §134.250 (4)(B) states that the designated doctor shall be reimbursed $50.00 for each additional impairment rating calculation. Therefore, the correct MAR for this service is $50.00.

   The submitted documentation indicates that Kevin McAlpin, D.C., performed examinations to determine the extent of the compensable injury and whether disability was related to the compensable injury. According to 28 TAC §134.235, the MAR for such examinations is $500.00. Designated doctor rules for multiple examinations of this type are found at 28 TAC §134.240 (2). Not including maximum medical improvement and impairment rating, when multiple examinations of this type are required, the first examination is reimbursed at 100% of MAR. The second examination is reimbursed at 50%. Additional examinations are reimbursed at 25%.

   For this dispute, the MAR for the examination to determine the extent of the compensable injury is $500.00. The MAR for the examination to determine the relatedness of disability is $250.00.

   The total allowable reimbursement for the services in question is $1,450.00.

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 reimbursement in the amount of $1,450.00 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 American Zurich Insurance Co. must remit to Kevin McAlpin, D.C. $1,450.00 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 | April 16, 2024<br>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.