



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Mahesh Mohan, M.D.

Respondent Name

Lockheed Martin Corp.

MFDR Tracking Number

M4-24-1340-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

February 16, 2024

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 13, 2023	Examination to Determine Maximum Medical Improvement and Impairment Rating – 99456-WP	\$0.00	\$0.00
	Examination to Determine the Extent of Injury – 99456-RE	\$0.00	\$0.00
	Examination to Determine Ability to Return to Work – 99456-RE	\$0.00	\$0.00
	Multiple Impairment Calculations 99456-MI	\$100.00	\$0.00
Total		\$100.00	\$0.00

Requestor's Position

"POST DESIGNATED DOCTOR EXAM INCORRECT REDUCTION"

Amount in Dispute: \$100.00

Respondent's Position

"... we have escalated the bills in question for manual review to determine if additional monies are owed."

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:

- 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. What services are considered in this dispute?
2. Is Mahesh Mohan, M.D. entitled to additional reimbursement for the examination in question?

Findings

1. Dr. Mohan is seeking additional reimbursement for an examination to determine maximum medical improvement (MMI); impairment rating (IR), including multiple calculations of impairment; extent of the compensable injury; and ability to return to work.

The requestor is seeking \$0.00 for the examinations to determine MMI, IR, extent of the compensable injury, and ability to return to work. Therefore, these services will not be considered in this dispute. Dr. Mohan is seeking \$100.00 for calculating multiple impairments. This service is considered in this dispute.

2. 28 TAC §134.250(4)(B) reserves reimbursement for multiple impairment ratings performed as part of a **designated doctor** examination. The evidence presented with the dispute request does not support that this service was provided as part of a designated doctor examination. Therefore, no reimbursement can be 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

_____	_____	June 13, 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 electrónico CompConnection@tdi.texas.gov.