



# Amended Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**

Mandy Woods, D.C.

**Respondent Name**

Arch Insurance Co.

**MFDR Tracking Number**

M4-24-1592

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

March 21, 2024

## Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 13, 2023	Designated Doctor Examination 99456-W5-WP	\$150.00	\$150.00

## Requestor's Position

"THE CURRENT RULES ALLOW REIMBURSEMENT"

**Amount in Dispute:** \$150.00

## Respondent's Position

"The provider included in her DWC 60 packet, a narrative report based upon her exam. She identified three diagnosis involving the (redacted), the (redacted) and the (redacted) ... there were only two body areas involved. They were the right upper extremity and the (redacted). Both the (redacted) are treated as one body area ... she was entitled to bill for the spine and for the upper extremities. However, the (redacted) are one extremity ... The provider has been paid \$800 based upon \$350 for the MMI exam, \$300 for the first body area because it included range of motion testing and \$150 for the second body area. The provider is not entitled to any additional payment."

**Response Submitted by:** Flahive Ogden & Latson

## Findings and Decision

### Authority

By Official Order Number 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 \(TAC\) §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:

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- N600 – Adjusted based on the applicable fee schedule for the region in which the service was rendered.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation, we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 2005 – No additional reimbursement allowed after review of appeal/reconsideration.
- MA46 – Alert: The new information was considered but additional payment will not be issued.

### Issues

1. Is Mandy Woods, D.C. entitled to additional reimbursement for the examination in question?

### Findings

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

The submitted documentation supports that Dr. Woods performed an evaluation of maximum medical improvement as ordered by 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. Woods performed impairment rating evaluations of the (redacted and redacted) 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.

The submitted records also indicate that Dr. Woods performed an impairment evaluation of an (redacted and redacted). 28 TAC §134.250(4)(D) defines the fees for the calculation of an impairment rating for non-musculoskeletal body areas, including the skin. The MAR for the assignment of impairment rating for non-musculoskeletal body areas is \$150.00 each.

DWC finds that the total allowable reimbursement for the services in question is \$950.00. Per the explanation of benefits dated June 29, 2023, 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 Arch Insurance Co. must remit to Mandy Woods, 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

\_\_\_\_\_  
May 30, 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).