



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Jason Eaves, D.C.

**Respondent Name**

Texas Mutual Insurance Company

**MFDR Tracking Number**

M4-24-1628-01

**Carrier's Austin Representative**

Box Number 54

**DWC Date Received**

March 28, 2024

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 31, 2023	Designated Doctor Examination 99456-W5-WP	\$150.00	\$0.00

### Requestor's Position

"An MMI/IR examination was performed on 3/31/2023 to address maximum medical improvement and impairment rating. \$800.00 was billed for this evaluation. \$350.00 of the bill represents the MMI portion of the exam, \$300.00 of the bill represents the IR portion for the first body area with ROM, and \$150.00 of the bill represents the use of DRE."

**Amount in Dispute:** \$150.00

### Respondent's Position

"The Designated Doctor, Jason Eaves, DC, performed MMI and IR exam for the claimant on the dispute of service date above. Review of attached documentation does not support more than one body area was rated. The documentation attached shows only the upper extremity was reviewed for ROM/IR. The documentation provided by the Designated Doctor does not support DRE method."

**Response Submitted by:** Texas Mutual Insurance Company

## 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:

- CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 790 – This charge was reimbursed in accordance with the Texas Medical Fee Guideline.
- Notes: "ONLY ONE BODY AREA WAS RATED (UPPER EXTREMITY)."
- CAC-138 – Appeal procedures not followed, or time limits not met.
- 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.
- 879 – Rule 133.250(B)- Health care provider shall submit the request for reconsideration no later than 10 months from the date of service.

### Issues

1. Is Jason Eaves, D.C. entitled to additional reimbursement for the services in question?

### Findings

1. Dr. Eaves is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating performed on March 31, 2023.

The submitted documentation supports the claim that Dr. Eaves 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. Eaves performed impairment rating evaluations of the right upper extremity 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 total allowable reimbursement for the services in question is \$650.00. Per explanation of benefits dated May 2, 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

May 24, 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).