



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

JACK P MITCHELL

Respondent Name

INDEMNITY INSURANCE CO OF NORT

MFDR Tracking Number

M4-14-1348-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

January 14, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per Rule 133.304 (k) this facility and or it's licensed health care provider(s) is required to notify the carrier that it is dissatisfied with the carrier's final action on the enclosed medical bill(s). Therefore, the sender of the medical bill(s) is officially requesting the carrier to reconsider its action on the enclosed medical bill(s) because the health care provider(s) or facility is dissatisfied. Also per the above mentioned rule the sender is submitting this information via FAX."

Amount in Dispute: \$800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier did not request that the designated doctor address extent of injury. If the doctor has written authorization from DWC to address extent as a certified issue, he can provide it to the carrier for review."

Response Submitted by: Flahive, Ogen & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2013	Maximum Medical Improvement, Impairment Rating and Extent of Injury Examinations	\$800.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the medical guideline for workers' compensation specific services.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - No EOB's provided

Issues

- Did the requestor file the disputed services in accordance with 28 Texas Administrative Code 133.307?

2. Did the requestor file the disputed services in accordance with 28 Texas Administrative Code 133.204?
3. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307 (c) (1) (2) (J) a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier in accordance with this chapter and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (relating to General Medical Provisions).

Review of submitted documentation finds the requestor failed to submit copies of medical bills as originally submitted to the carrier.

2. 28 Texas Administrative Code §134.204 (i)(1)(j) states Maximum Medical Improvement and/or Impairment Rating (MMI/IR) examinations shall be billed and reimbursed as follows: (1) The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement plus the reimbursement for the body area(s) evaluated for the assignment of an IR. The MMI/IR examination shall include: (A) the examination; (B) consultation with the injured employee; (C) review of the records and films; (D) the preparation and submission of reports (including the narrative report, and responding to the need for further clarification, explanation, or reconsideration), calculation tables, figures, and worksheets; and, (E) tests used to assign the IR, as outlined in the AMA Guides to the Evaluation of Permanent Impairment (AMA Guides), as stated in the Act and Division rules in Chapter 130 of this title (relating to Impairment and Supplemental Income Benefits).

Review of submitted documentation provided by the requestor does not include the examination, reports and records for the examination performed for disputed service July 26, 2013. Therefore, procedure code 99456-WP-W5, 99456-RE-W6, 99456-WP-MI is not supported.

3. For the reasons stated above, the Division finds no additional reimbursement is due to the requestor.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

Date

08/28/14

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.