TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Karrn Bales, D.O.

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-18-1481-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 22, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of adjudication.

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider is seeking additional reimbursement of $50.00 based upon providing multiple certifications involving multiple body areas. However, the provider identified the total number of units as one."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 22, 2017	Multiple Impairment Ratings (99456-W5-WP-MI)	$50.00	$0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.10 sets out the requirements for completion of a medical bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for evaluations of maximum medical improvement and impairment ratings.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 00223 (P12) – Workers' compensation jurisdictional fee schedule adjustment
   - Z710 – The charge for this procedure exceeds the fee schedule allowance.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Karrn Bales, D.O. is seeking an additional $50.00 for calculating multiple impairment ratings for a designated doctor examination. Each additional calculation of impairment may be reimbursed at $50.00.[1] Dr. Bales was required to supply the requested number of units on its bill.[2] Submitted documentation indicates that Dr. Bales was seeking reimbursement for one additional calculation of impairment. The insurance carrier reimbursed $50.00 for this service. No additional reimbursement is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	August 2, 2018
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 in accordance with Rule §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 MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **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.

[1] 28 Texas Administrative Code §134.250(4)(B)
[2] 28 Texas Administrative Code §133.10(f)(1)(T)