



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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Simon J. Forster, D.C.

Respondent Name

American Zurich Insurance Company

MFDR Tracking Number

M4-18-3049-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

April 23, 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: \$500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment is pending verification of the W9 form."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 21, 2017	Designated Doctor Examination (99456-RE-W6)	\$500.00	\$500.00

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 §133.210 sets out the procedures for medical documentation.
2. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine the extent of the compensable injury.
5. The submitted documentation did not include explanations of benefits.

Issues

Is the requestor entitled to reimbursement for the examination in question?

Findings

Simon J. Forster, D.C. is seeking reimbursement for a designated doctor examination to determine the extent of the injured employee’s compensable injury.

The insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill.¹ This deadline is not extended by a request for additional information. The insurance carrier failed to provide evidence that it took final action as required.

Therefore, Dr. Forster is entitled to reimbursement for the service in question, in accordance with relevant statutes and rules.

The designated doctor is to bill an examination to determine extent of injury with CPT code 99456 and modifier “RE.” Reimbursement is \$500.00 and includes DWC-required reports.² The submitted documentation indicates that Dr. Forster performed an examination to determine the extent of injured employee’s injury. Reimbursement of \$500.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$500.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$500.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	January 9, 2019
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 §133.240(a)

² 28 Texas Administrative Code §134.235