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
Julio Santiago, D.C.

Respondent Name
Great Midwest Insurance Company

MFDR Tracking Number
M4-19-2053-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 10, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = 350.00
Knee IR w/ ROM = 300.00
Spine IR = 150.00
Total Paid = 650.00
Balance Due = 150.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier's Austin representative acknowledged receipt of the copy of this medical fee dispute on December 18, 2018. The insurance carrier's response is considered timely if it is submitted within 14 calendar days after the date the insurance carrier's representative received the copy of the dispute. If a response is not received within 14 calendar days of the dispute notification, then the decision may be based on the available information.[1]

No response has been received on behalf of Great Midwest Insurance Company to date. For that reason, the decision will be based on the information available.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 7, 2018	Designated Doctor Examination	$150.00	$150.00

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.

[1] 28 Texas Administrative Code §133.307(d)(1)

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. The insurance carrier reduced 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.
   - W3 – Additional payment made on appeal/reconsideration.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 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.

Issues

What is the total allowable reimbursement for the designated doctor examination in dispute?

Findings

Dr. Santiago is seeking an additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating performed on July 7, 2018. This examination was performed in association with an examination to determine the extent of the injured employee's compensable injury.

The submitted documentation supports that Dr. Santiago performed an evaluation of maximum medical improvement as ordered by the DWC. Reimbursement is $350.00 for this examination.[2] Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

Review of the submitted documentation finds that Dr. Santiago performed impairment rating evaluations of bilateral knee sprain and the spine. All body areas are considered in the number of units for the determination of impairment rating, as any possible outcome considered by the designated doctor may be finally adjudicated as the extent of the compensable injury. The physical examinations of these musculoskeletal body areas included range of motion testing. The MAR for the evaluation of the first musculoskeletal body area performed with range of motion is $300.00.[3] The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00.[4] The total MAR for the determination of impairment rating is $450.00.

The total allowable reimbursement for the disputed services is $800.00. The insurance carrier reimbursed $650.00. An additional reimbursement of $150.00 is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services.
The DWC hereby ORDERS the respondent to remit to the requestor $150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

[2] 28 Texas Administrative Code §134.250(3)(C)
[3] 28 Texas Administrative Code §134.250(4)(C)(ii)(II)(-a-)
[4] 28 Texas Administrative Code §134.250(4)(C)(ii)(II)(-b-)

Authorized Signature

	Laurie Garnes	April 3, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.