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
Jack P. Mitchell, D.C.

Respondent Name
Zurich American Insurance Company of Illinois

MFDR Tracking Number
M4-19-2547-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 11, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The provider should be reimbursed for First determining MMI for $350.00, then Secondly for a full exam to lower extremity at $300.00 for a total of $650.00"

Amount in Dispute: $650.00

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 January 18, 2019. 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 Zurich American Insurance Company of Illinois 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
November 8, 2018	Designated Doctor Examination	$650.00	$650.00

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 (DWC).

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

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

medical improvement.
3. The insurance carrier reduced payment for the disputed examinations based on compensability.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. Is the requestor entitled to reimbursement for the examinations in question?

Findings

1. Dr. Mitchell is seeking reimbursement of $650.00 for a designated doctor examination. The insurance carrier denied payment based on compensability. The examination in question was ordered by the Commissioner of the DWC. Therefore, a denial based on compensability is not supported.
2. Reimbursement is $350.00 for an examination to determine maximum medical improvement.[2] Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[3] The total allowable reimbursement for the examinations in question is $650.00. This amount 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 $650.00.

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 $650.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

______________________	Laurie Garnes	April 11, 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.

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[2] 28 Texas Administrative Code §134.250(3)(C)

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