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
Medical Evaluators of Texas

Respondent Name
Starr Indemnity & Liability Company

MFDR Tracking Number
M4-19-2846-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Rai examined the IW on 10/12/2018 and as a result of her examination and careful review of the available records, Dr. Rai determined that the IW had reached MMI … with a resultant … impairment rating … According to Texas Administrative Code, this examination is to be billed and reimbursed as follows: If it is determined that a patient has reached MMI the Designated Doctor will charge $350.00 and will bill as 99456-W5. In addition to the $350.00 for MMI Assessment the Designated Doctor will charge $150.00 for the first area of examination when range of motion was not performed."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… we have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 12, 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.

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 examination to determine maximum medical improvement.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - Z710 – The charge for this procedure exceeds the fee schedule allowance.
   - 0950 – This bill is a reconsideration of a previously reviewed bill, allowance amounts do not reflect previous payments.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

Is Dr. Rai entitled to additional reimbursement?

Findings

Dr. Rai is seeking additional reimbursement for a designated doctor examination performed on October 12, 2018.

The submitted documentation supports that Dr. Rai performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00. [1]

Review of the submitted documentation also finds that Dr. Rai performed an impairment rating evaluation of the right eye. The MAR for the evaluation of a non-musculoskeletal body area is $150.00.[2]

The total MAR for the examination in dispute is $500.00. The insurance carrier reimbursed $350.00. An additional $150.00 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 $150.00.

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 $150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	July 18, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §134.250(3)(C)
[2] 28 Texas Administrative Code §134.250(4)(D)(v)

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.