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
Benjamin Burris, M.D.

Respondent Name
Chubb Indemnity Insurance Company

MFDR Tracking Number
M4-19-4571-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
June 20, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "NON PAYMENT FOLLOWING CARRIER'S RECEIPT OF INITIAL SUBMISSION"

Amount in Dispute: $950.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Although the billing in question was never, submitted for review prior to receipt of the medical fee dispute, the carrier has agreed to allow reimbursement in accordance with the Act and division rules."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2019	Examination to Determine Maximum Medical Improvement and Impairment Rating	$950.00	$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 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:
   - 219 – Based on Extent of Injury
   - 510 – Payment Determined
   - P12 – Workers' Compensation State Fee Schedule Adj
   - Notes: "Referral MD performing MMI/IR using ROM for 2 body areas (spine and knee)"

Issues

1. Is this dispute subject to dismissal based on extent of injury?
2. Is Dr. Burris entitled to additional reimbursement?

Findings

1. Dr. Burris seeking reimbursement for an examination to determine maximum medical improvement and impairment rating performed on February 28, 2019. Per explanation of benefits dated April 10, 2019, the insurance carrier denied the examination based on the extent of the compensable injury.

   Documentation submitted to the DWC indicates that the insurance carrier did not maintain this denial in its position statement or subsequent explanation of benefits. Therefore, this dispute is not subject to dismissal based on extent of injury.

2. Per the subsequent explanation of benefits dated August 6, 2019, the insurance carrier reduced the billed amount, citing the fee guidelines.

   The records submitted show that Dr. Burris billed $950.00 for three units for the examination in question. The insurance carrier paid a reduced amount of $800.00.

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

   Review of the submitted documentation finds that Dr. Burris performed impairment rating evaluations of three body areas: The left knee, spine, and mouth. The MAR for the evaluation of the left knee, a musculoskeletal body area performed with range of motion is $300.00.[2] The MAR for the evaluation of the spine, a subsequent musculoskeletal body area, is $150.00.[3] The MAR for the evaluation of the mouth, a non-musculoskeletal body area is $150.00.[4] The total MAR for the determination of impairment rating is $600.00.

   The total allowable for the examination in question is $950.00. Therefore, an additional $150.00 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 DWC 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 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.

Authorized Signature

	Laurie Garnes	October 11, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §134.250(3)(C)
[2] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-b-)
[4] 28 TAC §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 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.