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
David West, D.O.

Respondent Name
Mid-Century Insurance Company

MFDR Tracking Number
M4-19-4572-01

Carrier's Austin Representative
Box Number 14

MFDR Date Received
June 20, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "**DWC Rule 130.1** … indicates the treating doctor may refer the injured employee for evaluation of MMI and/or permanent whole body impairment to a doctor in place of the treating doctor and that there is no requirement for the treating doctor to refer the examinee to a doctor that is in the same treatment network as the treating doctor but only that the referral doctor performing the certifying examination be an authorized doctor that is certified … In this case, the provider on this claim is certified and meets all of the DWC requirements. The certifying doctor IS NOT required by rule to be part of the same healthcare network as the treating doctor."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Although the injured worker referenced above is an in-network employee the requestor, David Adam West, DO is not, contracted or employed with CorVel as a certified network provider. To date CorVel has no record of an out-of-network request from the network treating doctor or David Adam West, DO for approval by the CorVel Texas CorCare Network for out-of-network health care prior to services being, rendered by the requestor."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 17, 2018	Examination to Determine Maximum Medical Improvement	$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.

Background

1. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 243 – Srvs. Not authorized by network/primary care prov
   - NNP – Out-of-network approval not requested prior to rendering services

Issues

1. Are the insurance carrier's reasons for reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Dr. West is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating on referal from the injured employee's treating doctor. The insurance carrier denied payment based on lack of network approval.

   Review of the documentation submitted to the DWC finds that no evidence was presented to support that the claim involved in this dispute is part of a certified healthcare network.[1] The DWC concludes that the insurance carrier's denial for this reason is not supported.

2. The submitted documentation supports that Dr. West performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement for this examination is $350.00.[2]

   The submitted documentation supports that Dr. West provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the left leg. 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 disputed services is $650.00. This amount 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 $650.00.

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 $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	September 10, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §§133.240(f)(15) and 133.307(d)(2)
[2] 28 TAC §134.250(3)(C)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-a-)

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.