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
Benjamin Burris, M.D.

Respondent Name
American Casualty Company of Reading PA

MFDR Tracking Number
M4-19-4858-01

Carrier's Austin Representative
Box Number 57

MFDR Date Received
July 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "WE HAVE MADE MULTPLE ATTEMPS TO GET AN EOB, OR CORRESPONDENCE FOR THIS CLAIM. HOWEVER THE CARRIER HAS NOT PROVIDED ONE."

Amount in Dispute: $1,800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Carrier issued payment in the amount of $1450.00"

Response Submitted by: Brian J. Judis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 17, 2019	Examination to Determine Maximum Medical Improvement and Impairment Rating	$1,250.00	$0.00
January 17, 2019	Examination to Determine Extent of Injury	$500.00	$0.00
January 17, 2019	Multiple Impairment Calculations	$50.00	$0.00
	Total	$1,800.00	$0.00

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 §134.235 sets out the fee guidelines for examinations to determine extent of injury.
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 citing fee guidelines.

Issues

Is Dr. Burris entitled to additional reimbursement?

Findings

Dr. Burris is seeking additional reimbursement for an examination performed on January 17, 2019. Dr. Burris was selected by the treating doctor acting in place of the treating doctor for this examination.

In subsequent communication, Dr. Burris confirmed that the insurance carrier had paid $1,450.00. Per explanation of benefits dated May 17, 2019, the insurance carrier paid the full amount for the examination to determine maximum medical improvement and impairment rating for five units. Therefore, these services will not be considered in this dispute.

This explanation of benefits also indicates that the insurance carrier paid the charges for multiple impairments in full. This service will not be considered in this dispute.

Dr. Burris charged $500.00 for an examination to determine the extent of the injury, represented by CPT code 99456 and modifier "RE." The explanation of benefits shows that the insurance carrier paid $150.00 for this examination. This service is reviewed in this dispute.

When an examination to determine the extent of the injury is requested by the DWC or the insurance carrier, the doctor will bill the examination using CPT code 99456 and modifier "RE." The fee for this examination is $500.00. See 28 TAC §134.235.

The documentation submitted to the DWC does not indicate that the examination in question was requested by the DWC or the insurance carrier. Therefore, 28 TAC §134.235 does not apply in this case. No additional reimbursement can be 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 not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	October 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 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.