



# 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**

Med-Loss, Inc.

**Respondent Name**

XL Specialty Insurance Company

**MFDR Tracking Number**

M4-19-5272-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

August 23, 2019

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "... the patient was seen for a designated doctor evaluation. Total fees as allowed by the Texas Fee Guideline were in the amount of \$415.00. However, to date we have not received payment from the carrier."

**Amount in Dispute:** \$415.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 28, 2018	Designated Doctor Examination (99456-W5-NM)	\$350.00	\$350.00
August 28, 2018	Incorporated Specialist Report (99456-SP)	\$50.00	\$0.00
August 28, 2018	Special Reports (99080)	\$15.00	\$0.00
Total		\$415.00	\$350.00

### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
- The documents received by the DWC do not include explanations of benefits.

## **Issues**

1. Did XL Specialty Insurance Company respond to the medical fee dispute?
2. Did XL Specialty Insurance Company take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
3. Is Med-Loss, Inc. entitled to additional reimbursement for the services in question?

## **Findings**

1. The Austin carrier representative for XL Specialty Insurance Company is Flahive, Ogden & Latson. Flahive, Ogden & Latson received the copy of this medical fee dispute on September 10, 2019. If the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.<sup>1</sup>

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. Med-Loss, Inc. is seeking reimbursement for a designated doctor examination to determine maximum medical improvement (MMI) and impairment rating (IR).

Evidence supports that Med-Loss, Inc. submitted a bill for the examination to an address presented on the "Request for Designated Doctor Examination" (Form DWC032) on or about September 27, 2019.

The insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information.<sup>2</sup>

The greater weight of evidence presented to the DWC supports that a complete bill for the services in question was received by the insurance carrier or its agent. No evidence was provided to support that the insurance carrier took final action on the bill for the service in question.

3. Because the insurance carrier failed to defend a denial of payment for the examination in question, the DWC finds that Med-Loss, Inc. is entitled to reimbursement.

The submitted documentation supports that Dr. Gilbert Mayorga performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is \$350.00.<sup>3</sup> Because Dr. Mayorga determined that the injured employee was not at maximum medical improvement, no impairment rating was performed.

When performing an examination to assign impairment rating for a non-musculoskeletal body area, the designated doctor may refer testing needed to a specialist. The designated doctor shall bill procedure code 99456 with modifier "SP" to incorporate this testing into the examination report.<sup>4</sup> Because no impairment rating was performed for this examination, Med-Loss, Inc. is not entitled to additional reimbursement for this service.

Med-Loss, Inc. is also seeking reimbursement for special reports billed with procedure code 99080. All reports associated with performing an examination to determine maximum medical improvement are included in the fee for the examination.<sup>5</sup> Med-Loss, Inc. is not entitled to reimbursement for this service.

The total allowable amount for the disputed services is \$350.00. 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 \$350.00.

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<sup>1</sup> 28 TAC §133.307(d)(1)

<sup>2</sup> 28 Texas Administrative Code §133.240(a)

<sup>3</sup> 28 TAC §134.250(3)(C)

<sup>4</sup> 28 TAC §134.250(4)(D)

<sup>5</sup> 28 TAC §134.250(1)(D)

**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 \$350.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

_____	_____ Laurie Garnes _____	_____ November 8, 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.**