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
Brent D. Dreier, D.C.

Respondent Name
Mitsui Sumitomo Insurance Company of America

MFDR Tracking Number
M4-19-5314-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 27, 2019

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $50.00

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
June 13, 2019	99456-W5-MI	$50.00	$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 (DWC).

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 guideline for examinations to determine maximum medical improvement and impairment rating.

Issues

1. Did Dr. Dreier provide a position statement for this dispute?
2. Did the insurance carrier respond to the medical fee dispute?
3. Is Dr. Dreier entitled to additional reimbursement?

Findings

1. Dr. Dreier is has requested medical fee dispute resolution for additional reimbursement of a designated doctor examination that included multiple impairment ratings. The requestor has a duty to include a position statement for the dispute that includes:

    - Reasons why the disputed fees should be paid,
    - How the Labor Code and DWC rules affect the disputed fee issues, and
    - How the evidence submitted with the dispute supports the requestor's position for each fee issue.[1]

    No position statement was received with the dispute. We will base this decision on the information available.

2. The Austin carrier representative for Mitsui Sumitomo Insurance Company of America is Flahive, Ogden & Latson. Flahive, Ogden & Latson received the copy of this medical fee dispute on September 4, 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.[2]

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

3. When a designated doctor provides multiple impairment ratings, the doctor bills the service with procedure code 99456, adding modifier "MI." The doctor is entitled to payment of $50.00 for each additional impairment rating.[3]

    The documents submitted with the dispute include one additional impairment rating. The maximum payment for this is $50.00. The insurance carrier paid this amount. No additional reimbursement is recommended.

Conclusion

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	November 8, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §133.307(c)(2)(N)
[2] 28 TAC §133.307(d)(1)
[3] 28 TAC §134.250(4)(B)

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.