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**
EHSANZADEH CHEEMEH, PARVANEH

**Respondent Name**
Travelers Indemnity Company

**MFDR Tracking Number**
M4-20-0492-01

**Carrier's Austin Representative**
Box Number 5

**MFDR Date Received**
October 23, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION"

**Amount in Dispute:** $150.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Carrier has reviewed the billing and reimbursement and determined the Provider was appropriately reimbursed under Rule 134.250."

**Response Submitted by:** Travelers

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| April 17, 2019 | Designated Doctor Examination | $150.00 | $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 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:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204 (j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was also performed.
   - 863 – Reimbursement is based on the applicable reimbursement fee schedule.

- W3 – Additional payment made on appeal/reconsideration.
- 947 – Upheld. No additional allowance has been recommended.

**Issues**

Is Dr. Parvaneh Cheemeh entitled to additional reimbursement?

**Findings**

Dr. Parvaneh Cheemeh is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating. The insurance carrier reduced the payment citing fee guidelines.

The submitted documentation supports that Dr. Cheemeh performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement for this examination is $350.00.[1]

Review of the submitted documentation finds that Dr. Cheemeh performed impairment rating evaluations of upper respiratory complaints, shortness of breath and lower respiratory injury, eye complaints, and skin complaints. The MAR for the evaluation of non-musculoskeletal body areas is $150.00 each.[2]

| Examination | AMA Chapter | §134.250 Category | Reimbursement Amount |
|---|---|---|---|
| Upper Respiratory Complaints | Ear, Nose, Throat & Related Structures | Body Structures | $150.00 |
| Shortness of Breath & Lower Respiratory Injury | Respiratory System | Body Systems | $150.00 |
| Eye Complaints | Visual System | Body Systems | $150.00 |
| Skin Complaints | Skin | Body Structures | $150.00 |
| **Total MMI** | [redacted] | [redacted] | **$350.00** |
| **Total IR** | [redacted] | [redacted] | **$600.00** |
| **Total Exam** | [redacted] | [redacted] | **$950.00** |

The total allowable for the examination in question is $950.00. This was the amount paid by the insurance carrier. 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**

| Signature | Laurie Garnes<br>Medical Fee Dispute Resolution Officer | XXX<br>Date |
|---|---|---|

[1] 28 TAC §134.250(3)(C)
[2] 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**.