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
ELLIS, KEVEN MIRK

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-20-0772-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
November 25, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This was denied by the carrier and in a phone discussion with the adjuster, I was told it was their policy to only look at the scenario of the first DWC-69, which in this case the injured employee was not at MMI.

I believe this is in error and the fee for the injured employee reaching MMI and an IR performed should be paid based on scenario #2."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In order to resolve this fee reimbursement dispute Texas Mutual Insurance Company has elected to pay the disputed services."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 25, 2019	Designated Doctor Examination	$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 (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.

Issues

Is Keven Ellis, D.C. entitled to additional reimbursement for the examination in question?

Findings

Dr. Ellis is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating.

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

The submitted documentation supports that Dr. Ellis provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the lower extremities. Dr. Ellis billed this service, indicating one unit. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[2]

The total allowable reimbursement for the examination in question is $650.00. The submitted explanation of benefits dated January 15, 2020 shows that Texas Mutual Insurance Company paid this amount for this service. 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	January 29, 2020
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.

[1] 28 TAC §134.250(3)(C)

[2] 28 TAC §134.250(4)(C)(ii)(II)(-a-)