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
MED-LOSS INC

Respondent Name
TASB Risk Management Fund

MFDR Tracking Number
M4-20-1392-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
February 4, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We were paid $650.00 which is not according to the Texas Fee Guidelines. We were underpaid by $150.00. Therefore, we request that we be paid the additional $150.00 for the additional body area that was not reimbursed in the original payment."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "We have reimbursed the maximum allowed payment for the MMI (maximum medical improvement) portion of the charges and the maximum allowed for the range of motion testing. This testing included the upper extremities (left shoulder).

No additional payments were due since the additional testing that was done on the lower extremities was not requested per the DWC-32 (copy attached) and was not part of the accepted compensable injury."

Response Submitted by: TASB Risk Management Fund

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 13, 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.

Issues

Is Med-Loss, Inc. entitled to additional reimbursement for the examination in question?

Findings

Med-Loss, Inc. is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating performed on February 13, 2019. The insurance carrier reduced payment citing the fee guidelines.

The submitted documentation supports that Gilbert Mayorga, M.D. performed an evaluation of maximum medical improvement. The maximum allowable reimbursement for this examination is $350.00.[1]

The submitted documentation supports that Dr. Mayorga provided an impairment rating for the upper extremities, a musculoskeletal body area, performing a full physical evaluation with range of motion. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[2]

Med-Loss, Inc. argued in its position statement that reimbursement is requested for a second body area. The DWC found no evidence that Dr. Mayorga provided an impairment rating assessment for another body area.

The total allowable reimbursement for the examination in question is $650.00. This is 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

	Laurie Garnes	February 21, 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-)