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
VIA METROPOLITAN TRANSIT

MFDR Tracking Number
M4-20-1393-01

Carrier's Austin Representative
Box Number 16

MFDR Date Received
February 4, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "[The] impairment process resulted in four body areas being impaired using the range of motion model."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Based on the areas reviewed, the requestor should have received reimbursement for three body areas. The initial payment of $800.00 covered the MMI portion ($350.00) and two body areas ($300.00 + $150.00); therefore, an additional payment of $150.00 is due. The payment and explanation of review will come under separate cover from Tristar Risk Management."

Response Submitted by: REVIEWMED

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2019	Designated Doctor Examination	$300.00	$150.00

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?

Findings

Med-Loss, Inc. is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating. The insurance carrier reduced reimbursement citing fee guidelines.

The submitted documentation supports that Gilbert Mayorga, Jr., M.D. performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[1]

Review of the submitted documentation finds that Dr. Mayorga performed impairment rating evaluations of the spine, upper extremity, and lower extremity performed with range of motion testing. The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[2] The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each.[3] Dr. Mayorga stated that the rib contusion considered in this examination was a "non-ratable condition." The total MAR for the determination of impairment rating is $600.00.

The total allowable amount for the examination in question is $950.00. The submitted documentation supports that the insurance carrier paid $800.00. An additional reimbursement of $150.00 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 $150.00.

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 $150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 7, 2020 Date

[1] 28 TAC §134.250(3)(C)
[2] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-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.