



# 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**

SHORT, STEVEN

**Respondent Name**

TRAVELERS INDEMNITY CO OF AMERICA

**MFDR Tracking Number**

M4-20-1459-01

**Carrier's Austin Representative**

Box Number 5

**MFDR Date Received**

February 11, 2020

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED"

**Amount in Dispute:** \$350.00

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "... on 08-08-2019, the Division sent notice to the parties cancelling the appointment as Designated and the evaluation because the Division had determined the Provider was not qualified to conduct the evaluation."

**Response Submitted by:** Travelers

### SUMMARY OF FINDINGS

| Dates of Service   | Disputed Services             | Amount In Dispute | Amount Due |
|--------------------|-------------------------------|-------------------|------------|
| September 10, 2019 | Designated Doctor Examination | \$350.00          | \$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**

- 28 Texas Administrative Code §127.5 sets out the procedures for scheduling designated doctor appointments.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- Texas Labor Code §408.0041 sets out the requirements for a designated doctor examination.
- The insurance carrier denied payment for the disputed services with the following claim adjustment codes:
  - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
  - 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.
- 024B – Treatment appears to be excessive.
- W3 – Additional payment made on appeal/reconsideration.

**Issues**

Is Steven Short, D.C. entitled to reimbursement for the examination in question?

**Findings**

Dr. Short is seeking reimbursement for a designated doctor examination performed September 10, 2019. Travelers Indemnity Company of America argued that it denied the examination because the examination had been cancelled by the DWC.

Per available information, Dr. Short was notified on or about August 8, 2019, that the DWC cancelled the examination because the doctor was not qualified to perform the examination.

The insurance carrier is required to pay for designated doctor examinations unless prohibited by the commissioner.<sup>1</sup> Because the commissioner of the DWC ordered the cancellation of this designated doctor examination, Dr. Short is not entitled to reimbursement.

**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 | Medical Fee Dispute Resolution Officer | Date        |
|           |  | May 8, 2020 |

***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.**

<sup>1</sup> Texas Labor Code §408.0041 (h)(1)