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**
WILLIAMS, GARY RICHARD

**Respondent Name**
MID-CENTURY INSURANCE CO

**MFDR Tracking Number**
M4-20-1461-01

**Carrier's Austin Representative**
Box Number 14

**MFDR Date Received**
February 11, 2020

## *REQUESTOR'S POSITION SUMMARY*

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

**Amount in Dispute:** $300.00

## *RESPONDENT'S POSITION SUMMARY*

Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| August 27, 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.
3. The insurance carrier reduced payment for the disputed services citing fee guidelines.

**Issues**

1. Did Mid-Century Insurance Company respond to the medical fee dispute?
2. Is Gary R. Williams, M.D. entitled to additional reimbursement for the examination in question?

**Findings**

1. The Austin insurance carrier representative for Mid-Century Insurance Company is Farmers Insurance Group. The representative received the copy of this medical fee dispute on February 20, 2020. If the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.[1]

   As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. Dr. Williams is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating.

   The submitted documentation supports that Dr. Williams performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[2]

   Review of the submitted documentation supports that Dr. Williams performed impairment rating evaluations of the cervical spine, head, teeth, hearing, and vision. The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[3] The MAR for the evaluation of non-musculoskeletal body areas is $150.00 each.[4]

   The total MAR for the disputed examination is as follows:

| Examination | AMA Chapter | §134.250 Category | Reimbursement Amount |
|---|---|---|---|
| Maximum Medical Improvement | [redacted] | | $350.00 |
| IR: Right Arm (ROM) | Musculoskeletal System | Upper Extremities | $300.00 |
| IR: Head | Mental and Behavioral | Mental and Behavioral | $150.00 |
| IR: Tooth | Ear, Nose, Throat & Related Structures | Body Structures | $150.00 |
| IR: Hearing | | | |
| IR: Cataracts | Vision | Body Systems | $150.00 |
| **Total MMI** | [redacted] | | **$350.00** |
| **Total IR** | | | **$750.00** |
| **Total Exam** | | | **$1,100.00** |

   The total allowable amount is $1100.00. The insurance carrier paid $950.00. 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.

[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §134.250(3)(C)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[4] 28 TAC §134.250(4)(D)(v)

## *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**

| | | |
|---|---|---|
| | | April 23, 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**.