



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

HERITAGE NETWORK PHYSICIAN SERVICES

Respondent Name

SAFETY NATIONAL CASUALTY CORP

MFDR Tracking Number

M4-20-1597-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

February 24, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "All submitted charges and coding conform to DWC Rules 28 TAC Chapter 134: The rule states that reimbursement for a designated doctor examination Impairment Rating that the designated Dr. to answer a specific question is \$500.00 for the first question asked and answered."

Amount in Dispute: \$375.00

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

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: November 25, 2019, Designated Doctor Examination (99456-RE-W6), \$375.00, \$375.00

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 §134.235 sets out the fee guidelines for examinations to determine extent of injury.
3. 28 Texas Administrative Code §134.240 sets out the fee guidelines specific to designated doctor examinations.

Issues

1. Did Safety National Casualty Corporation respond to the medical fee dispute?
2. Is Heritage Network Physician Services entitled to additional reimbursement for the examination in question.

Findings

1. The Austin insurance carrier representative for Safety National Casualty Corporation is Flahive, Ogden & Latson. The representative received the copy of this medical fee dispute on March 3, 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. Heritage Network Physician Services is seeking additional reimbursement for an examination to determine the extent of the injured employee’s compensable injury. Safety National Casualty Corporation reduced the payment for the examination citing fee guidelines.

The submitted documentation indicates that Edward W. Smith, D.O. performed an examination to determine the extent of the injured employee’s compensable injury. Whether the doctor has also determined maximum medical improvement and impairment rating, the maximum allowable reimbursement for this examination is \$500.00.²

Therefore, the total allowable reimbursement for the examination in question is \$500.00. The insurance carrier paid \$125.00. An additional payment of \$375.00 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 \$375.00.

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 \$375.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		April 28, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

¹ 28 TAC §133.307(d)(1)
² 28 TAC §§134.235 and 134.240 (2)

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.