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
SKLAR, JOHN ANTHONY

Respondent Name
ACE AMERICAN INSURANCE CO

MFDR Tracking Number
M4-20-1831-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
April 6, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Doctor assigned multiple impairment ratings."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider will need to submit a reconsideration request with correct billing."

Response Submitted by: Helmsman Management Services, LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 12, 2019	Required Medical Examination	$50.00	$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.
3. 28 Texas Administrative Code §180.22 sets out the roles and responsibilities of medical providers.

Issues

Is Dr. Sklar entitled to reimbursement for the service in question?

Findings

Dr. Sklar is seeking reimbursement for the calculation of an additional impairment rating given as part of an examination performed at the request of the insurance carrier. Reimbursement is reserved for multiple impairment ratings performed as part of a **designated doctor**[1] examination.

The evidence presented with the dispute request does not support that this service was provided as part of a designated doctor examination. Therefore, no reimbursement can be 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

		April 28, 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 §180.22 (h)