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
DISABILITY EVALUATING CENTER

Respondent Name
HARTFORD CASUALTY INSURANCE CO

MFDR Tracking Number
M4-20-1944-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
April 13, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The auditing company on initial partial payment did not have the concussion with LOC listed as a diagnosis. I submitted a Request for Reconsideration and information that his was accepted and they are still denying paying the $150.00 additional which is allowed for a 2nd body area."

Amount in Dispute: $150.00

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
November 25, 2019	Designated Doctor Examination	$150.00	$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 with the following claim adjustment codes:
   - 119 – Benefit maximum for this time period or occurrence has been reached.
   - 186 – Additional charges received, but no additional allowance is recommended due to the maximum allowance for this admission has been reached.
   - 285 – Please refer to the note above for a detailed explanation of the reduction.

- 6766 – Specialty Bill Audit/Expert Code Review involving the application of code auditing rules and edits based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, and coding guidelines dev
- Notes: "The examining doctor may bill for a maximum of 3 musculoskeletal body areas (units), which are defined as follows:
  Spine and Pelvis
  Upper extremities and hands; and
  Lower extremities (including feet)
  Non musculoskeletal body areas are billed and reimbursed using the appropriate CPT code(s) for the test(s) required for the assignment of IR.
  Non-musculoskeletal body areas are defined as:
  Body Systems;
  Body structures(including skin); and
  Mental and behavioral disorders."

Issues

1. Did Hartford Casualty Insurance Company respond to the medical fee dispute?
2. Is Disability Evaluating Center entitled to additional reimbursement for the examination in question?

Findings

1. The Austin carrier representative for Hartford Casualty Insurance Company is Burns Anderson Jury Brenner. The representative was notified of this medical fee dispute on April 21, 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. Disability Evaluating Center is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating.

   The submitted documentation supports that Wright Singleton, 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.[2]

   Review of the submitted documentation finds that Dr. Singleton performed impairment rating evaluations of the right shoulder with range of motion testing and a head injury. 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 determination of impairment rating is $450.00.

   The total allowable reimbursement for the examination in question is $800.00. The insurance carrier paid $650.00. An additional reimbursement of $150.00 is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. 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

		June 2, 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.