



# 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**

HENDERSON, TIMOTHY DALE

**Respondent Name**

CHEROKEE INSURANCE CO

**MFDR Tracking Number**

M4-20-2128-01

**Carrier's Austin Representative**

Box Number 16

**MFDR Date Received**

May 4, 2020

### 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
December 12, 2019	Designated Doctor Examination (99456-W5-WP)	\$300.00	\$300.00

### 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 §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - P12 – Workers' compensation jurisdictional fee schedule adjustment.
  - 309 – The charge for this procedure exceeds the fee schedule allowance.
  - 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 is payable if a determination of the impairment caused by the compensable injury was also performed.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider’s contract, or carrier decision.

**Issues**

1. Did Cherokee Insurance Company respond to the medical fee dispute?
2. Is Timothy Henderson, D.C. entitled to additional reimbursement for the examination in question?

**Findings**

1. The Austin carrier representative for Cherokee Insurance Company is Adami, Shuffield, Scheihing, Burns. The representative was notified of this medical fee dispute on May 12, 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.<sup>1</sup>

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. Henderson is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating as ordered by the DWC.

The submitted documentation supports that Dr. Henderson performed an evaluation of maximum medical improvement. The maximum allowable reimbursement (MAR) for this examination is \$350.00.

The submitted documentation supports that Dr. Henderson provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the lumbar spine. Reimbursement is \$300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.<sup>2</sup>

The DWC finds that the total allowable reimbursement for the disputed services is \$650.00. The insurance carrier paid \$350.00. An additional reimbursement of \$300.00 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 \$300.00.

***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 \$300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

Signature	Medical Fee Dispute Resolution Officer	August 6, 2020 Date
-----------	--	------------------------

<sup>1</sup> 28 TAC §133.307(d)(1)  
<sup>2</sup> 28 TAC §134.250(4)(C)(ii)(II)(-a-)

### ***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.**