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
PETRASEK, JAN RIEFER

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-20-2167-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 4, 2020

REQUESTOR'S POSITION SUMMARY

"THE CLAIM WAS SUBMITTED ON 10/09/2019, THEN AGAIN ON 12/12/2019 AND OUR OFFICE HAS YET TO RECEIVE ANY RESPONSE FROM THE CARRIER. HOWEVER WHEN WE CALLED ON 01/16/2020 TO CHECK STATUS WE WERE TOLD THE CLAIM WAS DENIED. THE CARRIER DIDN'T ISSUE AN EOB ANY TIME AFTER DENIAL."

Amount in Dispute: $1,165.00

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
September 27, 2019	Designated Doctor Examination (99456-W5-WP)	$650.00	$650.00
September 27, 2019	Designated Doctor Examination (99456-W8-RE)	$500.00	$500.00
September 27, 2019	Work Status Report (99080)	$15.00	$0.00
	Total	$1,165.00	$1,150.00

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 §134.235 sets out the fee guidelines for examinations to determine the ability of an injured employee to return to work.
3. 28 Texas Administrative Code §134.239 sets out the guidelines regarding work status reports provided with DWC or insurance carrier requested examinations.
4. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum

medical improvement and impairment rating.
5. The submitted documentation did not include explanations of benefits.

Issues

1. Did American Zurich Insurance Company respond to the medical fee dispute?
2. Did American Zurich Insurance Company take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
3. Is Jan Petrasek, M.D. entitled to reimbursement for the services in question?

Findings

1. The Austin carrier representative for American Zurich Insurance Company is Flahive Ogden & Latson. 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.[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. Petrasek is seeking reimbursement for a designated doctor examination to determine maximum medical improvement, impairment rating, and the injured employee's ability to return to work. The doctor's agent argued that it had not received payment or an explanation of denial for medical bills submitted for the examination in question.

   The insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information.[2]

   The greater weight of evidence presented to the DWC supports that a complete bill for the services in question was received by the insurance carrier or its agent. No evidence was provided to support that the insurance carrier took final action on the bill for the service in question.

3. Because the insurance carrier failed to pay or raise any defense for denial of payment for the examinations in question, Dr. Petrasek is entitled to reimbursement.

   The submitted documentation supports that Dr. Petrasek performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[3]

   The submitted documentation supports that Dr. Petrasek provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the right ankle. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[4]

   The submitted documentation indicates that Dr. Petrasek performed an examination to determine the ability of the injured employee to return to work. The MAR for this examination is $500.00.[5] Filing the DWC073 is not separately payable when provided with a designated doctor examination.[6]

   The total allowable reimbursement for the examination in question is $1,150.00. This amount is recommended.

[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §133.240 (a)
[3] 28 TAC §134.250(3)(C)
[4] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[5] 28 TAC §134.235
[6] 28 TAC §§134.239 and 134.240

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 $1,150.00.

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 $1,150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		August 21, 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.