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
DEON, LAURA L

Respondent Name
WEST AMERICAN INSURANCE CO

MFDR Tracking Number
M4-20-2170-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
May 4, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CARRIER CLAIMED THAT DR. DEON WASN'T ON THE 'APPROVED DOCTOR LIST', AFTER SUBMITTING THE NECESSARY CLARIFYING DOCUMENTATION THE CARRIER DENIED THE RFR FOR THE SAME THING EVEN THOUGH IT WAS ADDRESSED ON THE RFR AND IN THE ATTACHED DOCUMENTATION."

Amount in Dispute: $950.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… Provider was not on the approved Doctor List."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 7, 2019	Examination to Determine Maximum Medical Improvement and Impairment Rating	$950.00	$950.00

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:
   - 811 – Charges denied because on this date of service, provider was not on the approved doctor list.
   - W3 – Additional payment made on appeal/reconsideration.

Issues

1. Is West American Insurance Company's reason for denial of payment supported?
2. Is Laura L. Deon, M.D. entitled to reimbursement for the examination in question?

Findings

1. Dr. Deon is seeking reimbursement for an examination to determine maximum medical improvement (MMI) and impairment rating (IR), acting in place of the treating doctor. The insurance carrier denied payment for this examination stating that Dr. Deon "was not on the approved Doctor List."

   Review of available information finds that Dr. Deon was certified and eligible to perform examinations to determine MMI and IR on the date of service. The DWC concludes that the insurance carrier's denial of payment is not supported.

2. Because the insurance carrier's denial of payment was not supported, Dr. Deon is entitled to reimbursement for the examination in question.

   The submitted documentation supports that Dr. Deon performed an evaluation of maximum medical improvement. The maximum allowable reimbursement (MAR) for this examination is $350.00.[1]

   Review of the submitted documentation finds that Dr. Deon performed impairment rating evaluations of the spine, head, and upper extremities. The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[2] The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each.[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 $600.00.

   The total allowable reimbursement for this examination is $950.00. This amount 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 $950.00.

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 $950.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		June 8, 2020
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §134.250(3)(C)
[2] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-b-)
[4] 28 TAC §134.250(4)(D)(v)

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.