



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

HENDERSON, TIMOTHY DALE

Respondent Name

METROPOLITAN TRANSIT AUTHORITY

MFDR Tracking Number

M4-20-2181-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

May 4, 2020

REQUESTOR'S POSITION SUMMARY

"DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION"

Amount in Dispute: \$520.32

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

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: February 14, 2020, Designated Doctor Examination (99456-W5-WP), \$520.32, \$520.32

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 submitted documentation submitted does not include explanations of benefits.

Issues

1. Did Metropolitan Transit Authority 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 Metropolitan Transit Authority 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. Because no evidence was provided to support a reduction in reimbursement of the examination in question, the DWC finds that Dr. Henderson is entitled to reimbursement.

The submitted documentation supports that Dr. Henderson performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement for this examination is \$350.00.²

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.³

The total allowable reimbursement for the examination in question is \$650.00. Dr. Henderson is seeking \$520.32. 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 \$520.32.

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 \$520.32, 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 21, 2020

Date

¹ 28 TAC §133.307(d)(1)

² 28 TAC §134.250(3)(C)

³ 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.