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
KUMAR-MISIR, VICTOR

Respondent Name
MITSUI SUMITOMO INSURANCE CO

MFDR Tracking Number
M4-20-2294-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 18, 2020

REQUESTOR'S POSITION SUMMARY

"CERTIFYING DOCTOR EXAMINATION NO PAYMENT RECEIVED"

Amount in Dispute: $800.00

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
March 10, 2020	Examination to Determine Maximum Medical Improvement and Impairment Rating (99456-WP)	$800.00	$800.00

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:
   - 16 – Claim/service lacks information which is needed for adjudication.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did Mitsui Sumitomo Insurance Company respond to the medical fee dispute?
2. Was the insurance carrier's denial of payment supported?
3. Is Victor Kumar-Misir, M.D. entitled to reimbursement for the examination in question?

Findings

1. The Austin carrier representative for Mitsui Sumitomo Insurance Company is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on May 27, 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. Kumar-Misir is seeking reimbursement for an examination to determine maximum medical improvement. The insurance carrier denied payment based on lack of information or billing errors. No evidence was presented to support this denial.

3. Because the insurance carrier failed to support its denial of payment for the examination in question, Dr. Kumar-Misir is entitled to reimbursement.

   The submitted documentation supports that Dr. Kumar-Misir performed an evaluation of maximum medical improvement. The maximum allowable reimbursement (MAR) for this examination is $350.00.[2]

   Review of the submitted documentation finds that Dr. Kumar-Misir performed impairment rating evaluations of the lumbar spine and left knee with range of motion testing. 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 subsequent 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. 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 $800.00.

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 $800.00, 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 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-)
[4] 28 TAC §134.250(4)(C)(ii)(II)(-b-)

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.