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
RMJ EVALUATIONS

Respondent Name
LIBERTY INSURANCE CORP

MFDR Tracking Number
M4-20-2404-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
June 4, 2020

REQUESTOR'S POSITION SUMMARY

"Please be advised that this was a Designated Doctor Evaluation requesting Extent of Injury from the Texas Department of Insurance dated September 19, 2019. Dr. Milton Kirkwood, D.O. performed the Extent of Injury examination on [the injured employee] on October 3, 2019 and billed Liberty Mutual in the amount of $500.00."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

"The visit for DOS 10/03/19 was denied as Peer Review states: 'Current treatments, including treatments for uveitis, are not related, appropriate, or medically necessary for the work injury.'"

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 3, 2019	Designated Doctor Examination	$500.00	$500.00

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 extent of the compensable injury.
3. Texas Labor Code §408.0041 sets out the requirements related to designated doctor examinations.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 203 – Peer review has determined – payment for treatment has not been recommended due to the lack of medical necessity. Peer review has provided its findings to the provider in prior documentation.

- W3 – Additional payment made on appeal/reconsideration

Issues

Is RMJ Evaluations entitled to reimbursement for the examination in question?

Findings

RMJ Evaluations is seeking reimbursement for a designated doctor examination to determine the extent of a compensable injury performed on October 3, 2019.

The submitted documentation indicates that Milton E. Kirkwood, D.O. performed an examination to determine the extent of the compensable injury. The submitted evidence shows that the commissioner of the DWC ordered the examination in question on September 9, 2019. The MAR for this examination is $500.00.[1]

The insurance carrier is required to reimburse designated doctor examinations ordered by the DWC unless otherwise prohibited.[2] Therefore, the DWC recommends reimbursement of $500.00 for the examination in question.

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 $500.00.

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 $500.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		June 29, 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.

[1] 28 TAC §134.235

[2] TLC §408.0041 (h)