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

Requester Name
MEDICAL EVALUATORS OF TEXAS

Respondent Name
AMERICAN ZURICH INSURANCE CO

MFDR Tracking Number
M4-20-2558-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 24, 2020

REQUESTER'S POSITION SUMMARY

Initial Statement: "As MET has electronic proof of two submissions of this claim, but the adjuster has not supplied payment or processing information, MET requests payment of this claim in the full amount of $1150.00."

Subsequent Statement: "I received partial payment for the claim on 08/21//2020 … MET received payment for the determination MMI, but not the IR. There is still a balance of $300.00 on this claim."

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

Initial Statement: "… we have escalated the bill in question for manual review to determine if additional monies are owed."

Subsequent Statement: "Our bill audit company has determined additional monies are owed. Attached is a copy of the EOB and payment summaries, which includes interest."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 13, 2019	Designated Doctor Examination (99456-WP-W5)	$300.00	$300.00

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 submitted documentation does not include explanations of benefits provided to the requester prior to its medical fee dispute resolution request.

Issues

Is Medical Evaluators of Texas entitled to additional reimbursement?

Findings

Medical Evaluators of Texas is seeking reimbursement for a designated doctor examination performed on November 13, 2019.

The insurance carrier made a partial payment after the request for medical fee dispute. Per submitted explanation of benefits, it reimbursed the examination to determine the ability of the injured employee to return to work in full. The fee for the examination to determine maximum medical improvement and impairment rating was reduced citing fee guidelines.

The submitted documentation supports that Shauna A. Wood, D.C. performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[1]

The submitted documentation supports that Dr. Wood provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the left shoulder. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[2]

The total allowed amount for the examination in dispute is $650.00. The insurance carrier paid $350.00. An additional reimbursement of $300.00 is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requester has established that additional reimbursement is due. As a result, the amount ordered is $300.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requester is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requester $300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		September 9, 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-)

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.