



# 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

**Requester Name**

VINCENT, DUANE F

**Respondent Name**

INDEMNITY INSURANCE CO OF NORTH AMERICA

**MFDR Tracking Number**

M4-20-2717-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

July 17, 2020

#### REQUESTER'S POSITION SUMMARY

"Dr. Vincent was asked to address MMI/IR/RTW and EOI ... **Texas Labor Code §408.0041 requires insurance carrier to reimburse designated doctors for examinations ordered by the Commissioner of Workers' Compensation.**"

**Amount in Dispute: \$150.00**

#### 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
December 6, 2019	Designated Doctor Examination (99456-W5-WP; 99456-W6-RE; 99456-W8-RE)	\$150.00	\$150.00

#### 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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
- Texas Labor Code §408.0041 sets out the requirements for designated doctor examinations.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - 308 – MMI/IR procedure code 99456 is permitted only once on the same date of service
  - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer.

## **Issues**

1. Did Insurance Company of North America respond to the medical fee dispute?
2. Is the examination in question subject to dismissal based on medical necessity?
3. Is Duane Vincent, D.C. entitled to additional reimbursement for the examination in question?

## **Findings**

1. The Austin carrier representative for Insurance Company of North America is Downs & Stanford, PC. The representative was notified of this medical fee dispute on July 21, 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.<sup>1</sup>

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. Vincent is seeking additional reimbursement for a designated doctor examination ordered by the DWC, which included the following:
  - Maximum Medical Improvement,
  - Impairment Rating,
  - Extent of Injury, and
  - Return to Work.

Insurance Company of North America reimbursed the examinations for maximum medical improvement, extent of injury, and return to work in full. The insurance carrier denied payment for impairment rating based on medical necessity. The DWC will review this examination in this dispute.

The insurance carrier is required to reimburse designated doctor examinations unless otherwise prohibited by statute, order, or rule.<sup>2</sup> The insurance carrier submitted no evidence to support that reimbursement for the portion of the examination in question was prohibited.

The DWC finds that the examination in question is not subject to dismissal based on medical necessity.

3. Because the insurance carrier failed to support its denial of payment for the service in question, Dr. Vincent is entitled to reimbursement.

The submitted documentation supports that Dr. Vincent provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the spine and upper extremities. According to the submitted copies of bills sent to the insurance carrier and the request for medical fee dispute resolution, Dr. Vincent is seeking reimbursement of \$150.00 for the impairment rating of one body area.<sup>3</sup> This amount 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 \$150.00.

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<sup>1</sup> 28 TAC §133.307(d)(1)

<sup>2</sup> TIC §408.0041 (h)

<sup>3</sup> 28 TAC §134.250(4)(C)(ii)

**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 \$150.00, 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

\_\_\_\_\_  
September 16, 2020  
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.**