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
MEDICAL EVALUATORS OF TEXAS

Respondent Name
STARBUCKS CORP

MFDR Tracking Number
M4-21-0031-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
September 9, 2020

REQUESTOR'S POSITION SUMMARY

"The complete/clean bill was submitted to the carrier for reimbursement on 03/09/2020 by MET Healthcare Solutions ("MET"), Dr. Azhdarinia's billing provider. The claim submission was made to the insurance carrier by fax …, as indicated by the adjuster on the DWC032 … No payment or explanation of review/benefits was received by MET within 45 days of claim submission. Therefore, the claim was submitted to the carrier … To date …, no payment or explanation of review/benefits has been received for this claim."

Amount in Dispute: $1,250.00

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
February 14, 2020	Designated Doctor Examination (99456-W5-WP)	$500.00	$500.00
February 14, 2020	Designated Doctor Examination (99456-W8-RE)	$500.00	$500.00
February 14, 2020	Designated Doctor Examination (99456-W6-RE)	$250.00	$250.00
	Total	$1,250.00	$1,250.00

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 §133.240 sets out the requirements for payment or denial of a medical bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine the extent of the compensable injury and the ability to return to work.

4. 28 Texas Administrative Code §134.240 sets out the fee guidelines for designated doctor examinations.
5. No explanations of benefits were received with this dispute.

Issues

1. Did Starbucks Corp. respond to the medical fee dispute?
2. Is the Medical Evaluators of Texas entitled to reimbursement for the examinations in question?

Findings

1. The Austin carrier representative for Starbucks Corp. is White Espey, PLLC. The representative was notified of this medical fee dispute on September 15, 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. Medical Evaluators of Texas is seeking reimbursement for a designated doctor examination performed on February 14, 2020. Because the insurance carrier failed to take final action on the submitted bill for the disputed services, the requestor is entitled to reimbursement.

   The submitted documentation supports that Parvin Azhdarinia, 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.[2]

   The submitted documentation supports that Dr. Azhdarinia provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the right upper extremity. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[3]

   The submitted documentation indicates that Dr. Azhdarinia performed an examination to determine the ability to return to work and the extent of the compensable injury. The MAR for such examinations is $500.00.[4] Not including maximum medical improvement and impairment rating, when multiple examinations of this type are required, the first examination is reimbursed at 100 %, the second examination is reimbursed at 50 %, and additional examinations are reimbursed at 25 %.[5] For this dispute, the MAR for the examination to determine the ability to return to work is $500.00. The examination to determine the extent of the compensable injury is $250.00.

   The total allowable reimbursement is $1,400.00. Medical Evaluators of Texas is seeking $1,250.00. 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 $1,250.00.

[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 §134.235
[5] 28 TAC §134.240 (2)

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 $1,250.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		December 16, 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.