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
UMC HEALTH SYSTEM

MFDR Tracking Number
M4-21-0032-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
September 9, 2020

REQUESTOR'S POSITION SUMMARY

"On 03/18/2020, MET received an explanation of review from the carrier denying all charges due to missing information. A request for reconsideration was submitted to the carrier on the same date with a copy of proof of original submission, showing that the claim was submitted completely, and according to all applicable Rules."

Amount in Dispute: $1,150.00

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
January 3, 2020	Designated Doctor Examination (99456-W5-WP)	$650.00	$650.00
January 3, 2020	Designated Doctor Examination (99456-W6-RE)	$500.00	$500.00
	Total	$1,150.00	$1,150.00

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

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. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s)

Issues

1. Did UMC Health System respond to the medical fee dispute?
2. Is the insurance carrier's denial of payment supported?
3. Is Medical Evaluators of Texas entitled to reimbursement for the examination in question?

Findings

1. The Austin carrier representative for UMC Health System is Downs Stanford, PC. 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 are seeking reimbursement for a designated doctor examination performed on January 3, 2020. UMC Health System denied payment based on information or errors in bill submission. No evidence was presented to support this denial.

3. Because the insurance carrier failed to support its denial of payment for the examinations in question, Medical Evaluators of Texas is entitled to reimbursement.

   The submitted documentation supports that Karla Haddock, 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. Haddock provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the right lower 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. Haddock performed an examination to determine the extent of the compensable injury. The MAR for this examination is $500.00.[4]

   The total allowable reimbursement for the services in question is $1,150.00. 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 $1,150.00.

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 $1,150.00, 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	December 16, 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 §134.235

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.