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

Requestor Name
OPTIMUM WELLNESS & REHAB CTR

Respondent Name
VANLINER INSURANCE CO

MFDR Tracking Number
M4-21-0265-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
October 13, 2020

REQUESTOR'S POSITION SUMMARY

The documentation initially submitted with the request for medical fee dispute resolution did not include a position statement from the requestor.

An addendum with the following statement was submitted on December 3, 2020: "I received a payment yesterday 12/02/202 for $1375. This bill was $1675. There is a balance of $300."

Amount in Dispute: $1,675.00

RESPONDENT'S POSITION SUMMARY

"As result of our review, the carrier has decided rather than to continue the dispute that it will process the Provider's bill for payment."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2020	Designated Doctor Examination (99456-W5-WP)	$800.00	$150.00
July 23, 2020	Designated Doctor Examination (99456-W6-RE)	$500.00	$0.00
July 23, 2020	Designated Doctor Examination (99456-W7-RE)	$250.00	$0.00
July 23, 2020	Designated Doctor Examination (99456-W8-RE)	$125.00	$0.00
	Total	$1,675.00	$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

1. 28 Texas Administrative Code §133.240 sets out the procedures 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 §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

Issues

1. What services are considered in this dispute?
2. Is Optum Wellness and Rehab Center entitled to additional reimbursement?

Findings

1. Optum Wellness and Rehab Center is seeking reimbursement for a designated doctor examination that included maximum medical improvement, impairment rating, extent of the compensable injury, disability, and the ability to return to work.

   After the request for medical fee dispute was filed, the insurance carrier paid $1,375.00. The examinations for the extent of the compensable injury, disability, and the ability to return to work were paid in full. Therefore, these services will not be considered in this dispute.

   Optum Wellness and Rehab Center was seeking $800.00 for the examination to determine maximum medical improvement and impairment rating. The insurance carrier reimbursed $500.00. The requestor is seeking an additional reimbursement of $300.00 for this service. Therefore, this examination will be considered in this dispute.

2. The submitted documentation supports that Kimberly Farrington, D.C. performed an evaluation of maximum medical improvement. The maximum allowable reimbursement (MAR) for this examination is $350.00.[1]

   The submitted documentation supports that Dr. Farrington provided an impairment rating, performing a full physical evaluation with range of motion of the lower extremity. 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 reimbursement for the examination considered in this dispute is $650.00. The insurance carrier paid $500.00. An additional reimbursement of $150.00 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 $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 $150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		January 8, 2021
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.