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
SMITH, EDWARD WILLIAM

Respondent Name
BITCO GENERAL INSURANCE CORP

MFDR Tracking Number
M4-21-0336-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 27, 2020

REQUESTOR'S POSITION SUMMARY

"One body area was rated for this examination. Range of motion measurements were required in this case."

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
August 28, 2020	Designated Doctor Examination (99456-W5-WP)	$150.00	$0.00

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.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - ORC – See additional information
   - Notes: "MMI/IR(DRE)1 AREA"
   - P12 – Workers' compensation state fee schedule adj
   - 18 – Duplicate claim/service
   - R1 – Duplicate billing

Issues

Is Edward W. Smith, D.O. entitled to additional reimbursement?

Findings

Dr. Smith is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating performed on August 28, 2020.

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

Review of the submitted documentation finds that Dr. Smith performed an impairment rating evaluation of a burn to an upper extremity burn. The skin is considered a non-musculoskeletal body area.[2] The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.[3]

The total allowable reimbursement for the examination in question is $500.00. This is the amount paid by the insurance carrier. No further reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 17, 2021 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.

[1] 28 TAC §134.250(3)(C)
[2] 28 TAC §134.250(4)(D)(i)(II)
[3] 28 TAC §134.250(4)(D)(v)