TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
SMITH, EDWARD WILLIAM

**Respondent Name**
PACIFIC INDEMNITY CO

**MFDR Tracking Number**
M4-21-0355-01

**Carrier's Austin Representative**
Box Number 17

**MFDR Date Received**
October 29, 2020

## *REQUESTOR'S POSITION SUMMARY*

"The rule states that reimbursement for a designated doctor examination Impairment Rating that includes multiple impairments as required by law is $50.00 for each additional impairment rating. A total of one additional impairment was required for this examination and was properly determined and submitted to the carrier."

**Amount in Dispute:** $50.00

## *RESPONDENT'S POSITION SUMMARY*

"Under the facts of this case, Edward William Smith, DO provided a DWC-69 for the compensable diagnosis code(s), of which he opined Claimant with MMI … and a 1% impairment rating … An 'alternate' DWC-69 was, submitted to address outstanding extent of injury questions, of which Edward William Smith, DO opined claimant had not reached MMI. Therefore, an impairment rating was not calculated."

**Response Submitted by:** CorVel

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| July 10, 2020 | Designated Doctor Multiple Impairment Ratings 99456-MI | $50.00 | $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 and impairment rating.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 234 – This procedure is not paid separately.

- 18 – Duplicate claim/service
- R1 – Duplicate billing

**Issues**

Is Edward W. Smith, D.O. entitled to additional reimbursement for the examination in question?

**Findings**

Dr. Smith is seeking reimbursement for an additional impairment rating associated with a designated doctor examination. The submitted documentation indicates that Dr. Smith was ordered to address maximum medical improvement, impairment rating, and extent of injury.

When multiple impairment ratings are required as a component of a designated doctor examination, the designated doctor shall be reimbursed $50 for each additional impairment rating calculation.[1]

The documentation submitted includes two Report of Medical Evaluation (DWC069) forms with impairment ratings provided. However, the narrative for the examination indicates that the impairment rating on both forms was for the same diagnoses of [redacted] of the [redacted] and [redacted] Because no evidence of an additional impairment rating was provided, the DWC finds that no additional 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 | January 29, 2021<br>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(4)(B)