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
CAZARES, RICK

Respondent Name
SAFETY NATIONAL CASUALTY CORP

MFDR Tracking Number
M4-21-0550-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
November 30, 2020

REQUESTOR'S POSITION SUMMARY

"DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION"

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 18, 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 and impairment rating.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

Is Rick Cazares, D.C. entitled to additional reimbursement for the examination in question?

Findings

Dr. Cazares is seeking additional reimbursement for an examination to determine maximum medical improvement and impairment rating.

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

The submitted documentation supports that Dr. Cazares provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the spine. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[2] The MAR for the evaluation of a musculoskeletal body area determined using the DRE method is $150.00.[3]

No evidence was submitted to support that range of motion testing was performed. The narrative submitted by the requestor indicates that the impairment rating was based on the DRE method.

The total reimbursable amount 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

		February 17, 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-)
[3] 28 TAC §134.250(4)(C)(ii)(I)

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.