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
VALDEZ, DANIEL CONDE

Respondent Name
GREAT MIDWEST INSURANCE CO

MFDR Tracking Number
M4-21-0622-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 4, 2020

REQUESTOR'S POSITION SUMMARY

"The impairment rating evaluation was performed by Dr. Valdez on 05/20/2020 was partially paid … [The injured employee] was evaluated for three body parts for the injury…"

Amount in Dispute: $225.00

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
May 30, 2020	Designated Doctor Examination (99456-W5-WP)	$225.00	$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:
   - 16 – Claim/Service lacks information or has submission/billing error(s which is needed for adjudication.
   - W3 – Additional payment made on appeal/reconsideration.
   - 1123 – We are unable to process the provider's re-billing, as the documentation does not specify the concern regarding the original analysis. Please re-submit with a clarification for the basis of the reconsideration.

Issues

1. Did Great Midwest Insurance Company respond to the medical fee dispute?
2. Is Daniel Valdez, M.D. entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Great Midwest Insurance Company is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on December 8, 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. Dr. Valdez is seeking an additional payment for a designated doctor examination performed on May 30, 2020. Dr. Valdez argued that the examination included determination of maximum medical improvement and impairment rating of three body areas.

   The submitted documentation does not support that Dr. Valdez billed the insurance carrier for three units. The evidence supports that the doctor billed for one unit.

   The maximum allowable reimbursement (MAR) for an examination to determine maximum medical improvement is $350.00.[2] Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[3]

   The total allowable reimbursement based on the submitted documentation is $650.00. The insurance carrier paid this amount in full. No further reimbursement is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. 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 26, 2021
Signature	Medical Fee Dispute Resolution Officer	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-)

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.