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
BOOKER, SHELLEY

Respondent Name
SOMPO AMERICA INSURANCE CO

MFDR Tracking Number
M4-21-0639-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 7, 2020

REQUESTOR'S POSITION SUMMARY

"Please be advised that on 9-21-20, I performed an evaluation for MMI and impairment rating on the above named patient … Total MAR includes $500 for assessment of MMI and I was already paid $350 for the assessment for MMI and still owed $150 for assessment of impairment rating for the lumbar spine."

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
September 21, 2020	Designated Doctor Examination (99456-W5-WP)	$150.00	$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 §133.307 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:
   - 00663 – Reimbursement has been calculated according to state fee schedule guidelines
   - 223 – Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.

- 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance is payable if a determination of the impairment caused by the compensable injury was also performed.
- P12-2 – Workers' compensation jurisdictional fee schedule adjustment.
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Did Sompo American Insurance Company respond to the medical fee dispute?
2. Is Shelley Booker, D.C. entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Sompo American Insurance Company is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on December 15, 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. Booker is seeking an additional reimbursement for a designated doctor examination performed on September 21, 2020.

   The submitted documentation supports that Dr. Booker performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[2]

   Review of the submitted documentation finds that Dr. Booker performed an impairment rating evaluation of the lumbar spine. The MAR for the evaluation of a musculoskeletal body area determined using the DRE method is $150.00.[3]

   The total allowable reimbursement for the disputed examination is $500.00. The insurance carrier paid $350.00. 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

Signature	Medical Fee Dispute Resolution Officer	February 26, 2021 Date

[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §134.250(3)(C)
[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.