



# 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**

WIGGINS, JOE W

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**MFDR Tracking Number**

M4-21-0856-01

**Carrier's Austin Representative**

Box Number 54

**MFDR Date Received**

January 26, 2021

### REQUESTOR'S POSITION SUMMARY

"AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED. THE CURRENT RULES ALLOW REIMBURSEMENT."

**Amount in Dispute:** \$800.00

### 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 17, 2020	Designated Doctor Examination (99456-W5-WP)	\$800.00	\$800.00

### 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**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
  - A26 – For further review of reimbursement, clarification of the rendering provider and date of exam is needed between the exam report & DWC69.
  - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.

## Issues

1. Did Texas Mutual Insurance Company respond to the medical fee dispute?
2. Is the insurance carrier's denial of payment supported?
3. Is Joe Wiggins, D.C. entitled to reimbursement?

## Findings

1. Texas Mutual Insurance Company was notified of this medical fee dispute on February 2, 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.<sup>1</sup>

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. Wiggins is seeking reimbursement for a designated doctor examination performed August 17, 2020. Texas Mutual Insurance Company denied payment stating, "For further review of reimbursement, clarification of the rendering provider and date of exam is needed between the exam report & DWC69."

Based on the evidence submitted, the rendering provider and date of the examination are the same on the bill, examination report, and DWC069 form. DWC concludes that this denial of payment is not supported.

3. Because Texas Mutual Insurance Company failed to support its denial of payment for the services in question, Dr. Wiggins is entitled to reimbursement.

The submitted documentation supports that Dr. Wiggins performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is \$350.00.<sup>2</sup>

Review of the submitted documentation finds that Dr. Wiggins performed impairment rating evaluations of the left wrist and right ankle with range of motion testing. The MAR for the evaluation of a musculoskeletal body area performed with range of motion is \$300.00.<sup>3</sup> The MAR for the evaluation of subsequent musculoskeletal body areas is \$150.00 each.<sup>4</sup> The total MAR for the determination of impairment rating is \$450.00.

The total allowable amount is \$800.00. This amount 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 established that additional reimbursement is due. As a result, the amount ordered is \$800.00.

## **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 \$800.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

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<sup>1</sup> 28 TAC §133.307(d)(1)

<sup>2</sup> 28 TAC §134.250(3)(C)

<sup>3</sup> 28 TAC §134.250(4)(C)(ii)(II)(-a-)

<sup>4</sup> 28 TAC §134.250(4)(C)(ii)(II)(-b-)

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
May 4, 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.**