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
JKB MEDICAL EXAMS

Respondent Name
HARTFORD INSURANCE COMPANY OF MIDWEST

MFDR Tracking Number
M4-21-0967-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
February 22, 2021

REQUESTOR'S POSITION SUMMARY

Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of adjudication.

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

"The date of service in dispute was process in accordance with 28 TAC Rule §134.240 & §134.250."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 9, 2020	Designated Doctor Examination (99456-MI)	$50.00	$50.00

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.

Issues

Is JKB Medical Exams entitled to reimbursement?

Findings

JKB Medical Exams is seeking additional reimbursement for the calculation of multiple impairment ratings for a designated doctor examination. The examination included determination of maximum medical improvement, impairment rating, and extent of injury.

When the examining doctor is required to do an evaluation of the extent of the compensable injury at the same time as maximum medical improvement and impairment rating, the doctor is required to provide multiple certifications of MMI and impairment ratings that considers each reasonable outcome for the extent of injury. These calculations are billed and reimbursed $50.00 for each calculation.[1]

The narrative report and enclosed forms support that these evaluations were performed, and two additional impairment ratings were provided. Therefore, the total allowable amount for this service is $100.00. The insurance carrier paid $50.00. An additional reimbursement of $50.00 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 $50.00.

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 $50.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		June 17, 2021
Signature	Medical Fee Dispute Resolution Officer	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)