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
COLLINS, CHARLES ANTHONY

Respondent Name
TRAVELERS INDEMNITY CO OF CONNECTICUT

MFDR Tracking Number
M4-21-1027-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
February 25, 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: $100.00

RESPONDENT'S POSITION SUMMARY

"In reviewing the documentation, the Provider determined the Claimant was not at MMI when considering the extent of injury determinations. Consequently, the DWC-69s completed for the two alternative extent findings reflect the Claimant is not at MMI and no impairment rating was calculated. As no impairment ratings were calculated for the alternative certifications, no reimbursement is due for calculating the non-existent ratings."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 7, 2021	Designated Doctor Examination (99456-MI)	$100.00	$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:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

- 973 – The reimbursement for this line item has been included in the payment recommendation(s) for all covered services which are reported on another line or lines.
- 947 – Upheld, no additional allowance has been recommended.

Issues

Is Charles Collins, D.C. entitled to additional reimbursement for the examination in question?

Findings

Dr. Collins is seeking reimbursement for multiple impairment ratings as part of a designated doctor examination performed January 7, 2021.

The submitted documentation indicates that Dr. Collins was ordered to address maximum medical improvement, impairment rating, and extent of injury. When multiple impairment ratings are required as a component of a designated doctor examination, the designated doctor shall be reimbursed $50 for each additional impairment rating calculation.[1]

Documentation supports that the designated doctor found that the injured employee was not at maximum medical improvement for two of the three scenarios reviewed, so no impairment calculations were provided for these scenarios. Therefore, a charge for additional impairment calculations was not supported. The DWC does not recommend additional reimbursement for this charge.

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

Signature	Medical Fee Dispute Resolution Officer	May 13, 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.

[1] 28 TAC §134.250(4)(B)