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
MOYA, SAMUEL ZARATE

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-21-1261-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 24, 2021

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $1,400.00

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
October 8, 2020	Designated Doctor Examination (99456-W5-WP)	$800.00	$800.00
October 8, 2020	Designated Doctor Examination (99456-W5-MI)	$100.00	$100.00
October 8, 2020	Designated Doctor Examination (99456-W6-RE)	$500.00	$500.00
	Total	$1,400.00	$1,400.00

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 §134.235 sets out the fee guidelines for examinations to determine extent of injury.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
4. The submitted documentation does not include explanations of benefits.

Issues

1. Did New Hampshire Insurance Company respond to the medical fee dispute?
2. Did New Hampshire Insurance Company take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
3. Is Samuel Z. Moya, D.C. entitled to reimbursement?

Findings

1. The Austin carrier representative for New Hampshire Insurance Company is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on March 30, 2021. 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. Moya is seeking reimbursement for a designated doctor examination to determine maximum medical improvement, multiple impairment ratings, and extent of the compensable injury. Dr. Moya argued that it had not received payment or an explanation of denial for medical bills submitted for the examination in question.

   The insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information.[2]

   The greater weight of evidence presented to the DWC supports that a complete bill for the services in question was received by the insurance carrier or its agent. No evidence was provided to support that the insurance carrier took final action on the bill for the service in question.

3. Because New Hampshire Insurance Company failed to provide any defense of its non-payment for the services in question, Dr. Moya is entitled to reimbursement.

   The submitted documentation supports that Dr. Moya performed an evaluation of maximum medical improvement. The maximum allowable reimbursement (MAR) for this examination is $350.00.[3]

   Review of the submitted documentation finds that Dr. Moya performed impairment rating evaluations of cervical spine and right elbow with range of motion testing. The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[4][5] The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each.[6] The total MAR for the determination of impairment rating is $450.00.

   The submitted documentation indicates that Dr. Moya was ordered to address maximum medical improvement, impairment rating, and extent of injury. The narrative report and enclosed forms support that these evaluations were performed, and two additional impairment ratings were provided. Therefore, the correct MAR for this service is $100.00.[7]

   The submitted documentation indicates that Dr. Moya performed an examination to determine the extent of the compensable injury. The MAR for this examination is $500.00.[8]

   The total allowable amount is $1,400.00. This amount is recommended.

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[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §133.240 (a)
[3] 28 TAC §134.250(3)(C)
[4] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[5] 28 TAC §134.250(4)(C)(ii)(I)
[6] 28 TAC §134.250(4)(C)(ii)(II)(-b-)
[7] 28 TAC §134.250(4)(B)
[8] 28 TAC §134.235

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 $1,400.00.

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 $1,400.00, 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.