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
C. Patricia Winter, M.D.

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-21-1303-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
March 30, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "A bill was admitted to Texas Mutual for services rendered which included evaluation of MMI ($350), IR for 2 body parts ($300 and $150) and extent of injury ($500) for a total of $1,150. Texas mutual sent a check dated 12/8/20 for $1,000 … We requested payment of Texas Mutual for the missing $150, and they sent a certified letter dated February 1, 2021 asking for refund of the $1,000 sent earlier … The refund was sent to Texas Mutual for $1000. It is my position that Texas Mutual acted and bad faith. At no time either before the Designated Doctor Evaluation or in the subsequent two weeks was I made aware that the evaluation had been canceled."

Amount in Dispute: $1,150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual filed a request for expedited BCCH and STAY of ordered Designated Doctor Exam on 10/15/2020. The Decision was approved by the ALJ … on 11/2/2020."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 3, 2020	Designated Doctor Examination	$1,150.00	$1,000.00

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.

Background

1. 28 Texas Administrative Code §127.1 sets out the procedures for scheduling designated doctor examinations.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

3. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine extent of injury.
4. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - A15 – Overpayment recoupment. Referred request under Division Rule 133.260
   - P13 – Payment reduced or denied based on Workers' Compensation jurisdictional regulations or payment policies.
   - Notes: "Requesting refund as per Decision And Order as the first certification Of MMI and assigned impairment Rating from Victor Abrego, MD on 7/31/17 became final under TX Labor code 408.123 and Rule 130/12 Cornelia Patricia Winter-Valdez, MD, was not properly Appointment to serve as accordance With TX Labor Code 408.0041 and Division rules. Dr. Winter is not Afforded presumptive weight on the Issues of MMI & IR."
   - Notes: "Requesting refund in the amount Of $1,000.00."

Issues

Is Cornelia Patricia Winter-Valdez, M.D. entitled to reimbursement for the examination in question?

Findings

Dr. Winter is seeking reimbursement for a designated doctor examination performed on November 3, 2020, ordered by the Commissioner of the DWC on October 13, 2020. Texas Mutual Insurance Company disputed the assignment of the examination on October 15, 2020.

A stay of examination was approved by the DWC on November 2, 2020. Submitted documentation indicates that Dr. Winter received notification after November 19, 2020. No evidence was submitted to support that either Dr. Winter or the injured employee was notified of the stay before the examination the next day.

Because the designated doctor and the injured employee were not notified of the cancelation of the examination before it was performed, Dr. Winter performed the examination as ordered. The insurance carrier is not relieved of reimbursement for the examination.

The submitted documentation supports that Dr. Winter performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[1]

Review of the submitted documentation finds that Dr. Winter performed an impairment rating evaluation for a hearing injury. The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.[2] The total MAR for the determination of impairment rating in this examination is $150.00.

The submitted documentation indicates that Dr. Winter performed an examination to determine the extent of the compensable injury. The MAR for this examination is $500.00.[3]

The total allowable reimbursement is $1,000.00. This amount is recommended.

[1] 28 TAC §134.250(3)(C)
[2] 28 TAC §134.250(4)(D)(v)
[3] 28 TAC §134.235

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered. For the reasons stated above, the Texas Department of Insurance, Division of Workers' Compensation (DWC) finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,000.00.

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 $1,000.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July 20, 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 division 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.