

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Carol Janine Miller, D.C.

Respondent Name

Arch Indemnity Insurance Company

MFDR Tracking Number

M4-21-2186-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

July 28, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
February 10, 2021	Designated Doctor Examination (99456-W5-WP)	\$150.00	\$150.00

Requestor's Position

"The appointment took place on 02/10/2021 and the complete/clean bill was submitted to the carrier for reimbursement on 02/19/2021. According to the EOB received on 02/26/2021, the claim was being denied for the procedure exceeding the fee schedule allowance.

On 03/16/2021, MET submitted a request for reconsideration with proof of timely submission and the reason(s) why MET stands by the claim as being complete and accurate ... the payor does not agree and has since issued a final decision to deny the request for payment."

Amount in Dispute: \$150.00

Respondent's Position

The Austin carrier representative for Arch Indemnity Insurance Company is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on August 3, 2021.

Per 28 Texas Administrative Code §133.307 (d)(1), 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.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 4150 – An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

Issues

1. Is Carol Janine Miller, D.C. entitled to additional reimbursement?

Findings

1. Dr. Miller is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating.

The submitted documentation supports that Dr. Miller performed an evaluation of maximum medical improvement as ordered by DWC. 28 TAC §134.250 (3)(C) states that the maximum allowable reimbursement (MAR) for this examination is \$350.00.

Review of the submitted documentation finds that Dr. Miller performed impairment rating evaluations of the lumbar spine. The rule at 28 TAC §134.250 (4)(C) defines the fees for the calculation of an impairment rating. The MAR for the evaluation of a musculoskeletal body area determined using the DRE method is \$150.00.

The total allowable reimbursement for the examination in question is \$500.00. The insurance carrier paid \$350.00. An additional reimbursement of \$150.00 is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has established that additional reimbursement of \$150.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Arch Indemnity Insurance Company must remit to Carol Janine Miller, D.C. \$150.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	October 11, 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 under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.