TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
Michael Leonard, M.D.

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-21-2272-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
August 11, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 2, 2021	Designated Doctor Examination Specialty Report (99456-SP)	$100.00	$0.00

Requestor's Position

"THE DD USED 3 DIFFERENT SPECIALTY REPORTS, THE HEARING REPORT, THE EYE AND THE NEUROPSYCH."

Amount in Dispute: $100.00

Respondent's Position

The Austin carrier representative for Indemnity Insurance Co of North America is Downs & Stanford, PC. The representative was notified of this medical fee dispute on August 17, 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:

- 00663 – Reimbursement has been calculated according to state fee schedule guidelines
- 5853-1 – The amount paid reflects a fee schedule reduction.
- 5920 – Fee schedule manually priced at billed charge
- 90223/P12 – Workers' Compensation jurisdictional fee schedule adjustement.
- 93 – No claim level adjustments.
- 90202/B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
- 247 – A payment or denial has already been recommended for this service.

Issues

1. Is Michael Leonard, M.D. entitled to additional reimbursement?

Findings

1. Dr. Leonard is seeking an additional reimbursement for including specialist reports in a designated doctor examination to determine maximum medical improvement and impairment rating.

   Documentation supports that Dr. Leonard referred the injured employee to three specialists for additional testing. 28 TAC §134.250 (4)(D)(iii) states that reimbursement is $50 for incorporating information from one or more specialists' reports into the final assignment of impairment rating for non-musculoskeletal body areas. This reimbursement shall be allowed only once per examination.

   Per explanation of benefits dated August 8, 2021, Indemnity Insurance Co of North America paid $50.00 for this service. No additional reimbursement can be 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 3, 2021 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 electronico CompConnection@tdi.texas.gov.