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
Gary R. Williams, M.D.

Respondent Name
North East ISD

MFDR Tracking Number
M4-22-0232-01

Carrier's Austin Representative
Box Number 55

DWC Date Received
October 5, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
June 10, 2021	Designated Doctor Examination (99456-W5-WP)	$350.00	$0.00

Requestor's Position

DESIGNATED DOCTOR EXAMINATION INCORRECT REDUCTION

Amount in Dispute: $350.00

Respondent's Position

Our bill review processed $350.00 on 10/18/21, check #xxxxx.

Response Submitted by: Athens Administrators

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 Texas Administrative Code §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:

- Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code
- This reconsideration reflects corrected charge amounts
- Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is Gary R. Williams, M.D. entitled to additional reimbursement for the examination in question?

Findings

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

   The submitted documentation supports that Dr. Williams performed an evaluation of maximum medical improvement. 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. Williams performed an impairment rating evaluation of the face. The rule at 28 TAC §134.250 (4)(D) defines the fees for the calculation of an impairment rating for non-musculoskeletal body areas. The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.

   The total allowable reimbursement for the examination in question is $500.00. Per explanation of benefits dated August 13, 2021, the insurance carrier paid $150.00. Explanation of benefits dated October 14, 2021, indicated the insurance carrier paid $350.00. DWC finds that Dr. Williams is not entitled to additional reimbursement.

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 is not due additional reimbursement.

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	December 20, 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.