

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Cody D. Mead, D.O.

Respondent Name

Zurich American Insurance Co.

MFDR Tracking Number

M4-22-1116-01

Carrier's Austin Representative

Box Number 19

DWC Date Received

February 10, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 2, 2021	Required Medical Examination 99456-WP	\$0.00	\$0.00
	Required Medical Examination 99456-RE	\$0.00	\$0.00
	Required Medical Examination 99456-MI	\$100.00	\$0.00
Total		\$100.00	\$0.00

Requestor's Position

Per the DWC022, Dr. Mead was asked to address Maximum Medical Improvement and Impairment Rating and Extent of compensable injury. Dr. Mead addressed 1 body area using Range of Motion (ROM). We were paid for all portions of the exam except 2 of Impairment Ratings scenarios.

Amount in Dispute: \$100.00

Respondent's Position

The Austin carrier representative for Zurich American Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on February 16, 2022.

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 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.
3. 28 TAC §180.22 sets out the guidelines for designated doctor examinations.

Denial Reasons

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

- 5920 – Fee schedule manually priced a billed charge.
- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 5853 – The amount paid reflects a fee schedule reduction.
- 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 Cody D. Mead, D.O. entitled to additional reimbursement?

Findings

1. Dr. Mead is seeking additional reimbursement for providing multiple impairment ratings as part of a required medical examination.

28 TAC §180.22 (h) and 28 TAC §134.250 (4)(B) reserve reimbursement for multiple impairment ratings performed as part of a designated doctor examination.

The evidence presented with the dispute request does not support that this service was

provided as part of a designated doctor examination. Therefore, no 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

May 20, 2022
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.