



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Gregory Sheppard, D.C.

**Respondent Name**

XL Specialty Insurance Co.

**MFDR Tracking Number**

M4-23-2469-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

May 26, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
January 12, 2023	Designated Doctor Examination 99456-W5-WP and 99456-W7-RE	\$1,150.00	\$1,150.00

### Requestor's Position

"AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED. THE CURRENT RULES ALLOW REIMBURSEMENT."

**Amount in Dispute:** \$1,150.00

### Respondent's Position

The Austin carrier representative for XL Specialty Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on June 6, 2023.

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 \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.240](#) sets out the procedures for payment or denial of a medical bill.
2. [28 TAC §133.307](#) sets out the procedures for resolving medical fee disputes.
3. [28 TAC §134.235](#) sets out the fee guidelines for examinations to determine if disability is related to the compensable injury.

### Denial Reasons

Neither party submitted an explanation of benefits with reasons for the denial of payment for the disputed services.

### Issues

1. Did XL Specialty Insurance Co. take final action on the bill for the disputed service before medical fee dispute resolution was requested?
2. Is Gregory Sheppard, D.C. entitled to additional reimbursement?

### Findings

1. Dr. Sheppard is seeking reimbursement for a designated doctor examination to determine maximum medical improvement, impairment rating, and if disability is related to the compensable injury. Dr. Sheppard argued that he did not receive payment or an explanation of denial for medical bills submitted for the examination in question.

Per 28 TAC §133.240 (a), the insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information.

The greater weight of evidence presented to DWC supports that a complete bill for the services in question was received by the insurance carrier or its agent. No evidence was provided to support that the insurance carrier took final action on the bill for the service in question.

2. Because the insurance carrier failed to provide any defense for non-payment of the services in question, Dr. Sheppard is entitled to reimbursement.

The submitted documentation supports that Dr. Sheppard 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. Sheppard performed impairment rating evaluations of the lumbosacral spine with range of motion testing. The rule at 28 TAC §134.250(4)(C)(ii) defines the fees for the calculation of an impairment rating for musculoskeletal body areas. The MAR for the evaluation of the first musculoskeletal body area performed with range of motion is \$300.00.

The submitted documentation indicates that Dr. Sheppard performed an examination to determine if the injured employee's disability was a direct result of the compensable injury. According to 28 TAC §134.235, the MAR for this examination is \$500.00.

The total allowable reimbursement for the services in question is \$1,150.00. This amount 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 requestor has established that additional reimbursement of \$1,150.00 is due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to reimbursement for the disputed services. It is ordered that XL Specialty Insurance Co. must remit to Gregory Sheppard, D.C. \$1,150.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

July 21, 2023  
\_\_\_\_\_  
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](http://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 three or email [CompConnection@tdi.texas.gov](mailto: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 tres o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).