TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Michael Maier, M.D.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-13-3238-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 5, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim was for a Division ordered Designated Doctor Exam. We billed a total of $350.00 for this claim and were paid nothing. The explanation given on the EOB justifying the denial states: *TEXAS STAR NETWORK DR. MAY NOT PERFORM DD EXAMS FOR WORKERS RECEIVING CARE THROUGH SAME NETWORK*; however, this is incorrect."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The following is the carrier's statement with respect to this dispute of 4/9/13. The requestor provided designated doctor services to the claimant on the date above and then billed Texas Mutual for this. Because the requestor and Texas Mutual claim … are both in the Texas Star Network, Texas Mutual declined to issue payment consistent with Rule 127.140(a)(6)."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 9, 2013	Designated Doctor Examination	$350.00	$0.00

FINDINGS AND DECISION

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

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §127.140 sets out the associations that disqualify a designated doctor from performing an examination in certain circumstances.
3. Texas Insurance Code §1305.101 sets out health care provisions for network claims.

4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-W1 – Workers' compensation state fee schedule adjustment
   - 788 – Texas Star Network Dr. may not perform DD exams for workers receiving care through the same network per Chapter 126 &/or 127 and rule 180.21.
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 724 – No additional payment after a reconsideration of services.

Issues

Are the insurance carrier's reasons for denial of payment supported?

Findings

Michael Maier, M.D. is seeking reimbursement for a designated doctor examination performed on April 9, 2013. Texas Mutual Insurance Company denied the disputed examination based on a network affiliation.

Insurance carriers are required to reimburse designated doctors based on relevant fee guidelines, unless the examination is otherwise prohibited.[1]

A doctor is disqualified from acting as a designated doctor if the doctor is part of the same network that covers the injured worker.[2]

Documentation submitted by the insurance carrier supports that Dr. Maier is part of the same network that covers the injured worker in this dispute. Dr. Maier was, therefore, prohibited from performing the examination in question. No reimbursement is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	August 8, 2018 Date

[1] Texas Labor Code §408.0041(h)

[2] 28 Texas Administrative Code §127.140(a)(6); Texas Insurance Code §1305.101(b)

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

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

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.