



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Sandra Silmon, D.C.

Respondent Name

Indemnity Insurance Co. of North America

MFDR Tracking Number

M4-24-0727-01

Carrier's Austin Representative

Box Number 15

DWC Date Received

November 28, 2023

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 5, 2023	Designated Doctor Examination 99456-W5-WP	\$300.00	\$300.00

Requestor's Position

"We initially submitted the bill totally \$650.00 on October 19, 2023. We received partial payment of \$350.00 with check date of November 10, 2023, ... This designated doctor bill should have been paid in full."

Amount in Dispute: \$300.00

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 December 5, 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 \(TAC\) §133.307](#) 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:

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 4150 – An allowance has been paid for a designated doctor examination as outlined I 134.204(j) for attainment of maximum medical improvement. An additional allowance is payable if a determination of the impairment caused by the compensable injury was also performed.
- TXP12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is Sandra Silmon, D.C. entitled to additional reimbursement for the services in question?

Findings

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

The submitted documentation supports the claim that Dr. Silmon performed an evaluation of maximum medical improvement as ordered by the 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. Silmon performed impairment rating evaluations of the (redacted) with range of motion testing. 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 total allowable reimbursement for the examination in question is \$650.00. The insurance carrier paid \$350.00. An additional reimbursement of \$300.00 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 \$300.00 is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Indemnity Insurance Co. of North America must remit to Sandra Silmon, D.C. \$300.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

_____	_____	March 27, 2024
Signature	Medical Fee Dispute Resolution Officer	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 three 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 tres o correo electrónico CompConnection@tdi.texas.gov.