TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pacific Billing Services, Inc.

Respondent Name
United Airlines, Inc.

MFDR Tracking Number
M4-19-4383-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS"

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 15, 2019	Designated Doctor Examination	$350.00	$350.00

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 §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement.
3. Texas Labor Code §408.0041 sets out the guidelines for designated doctor examinations.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 177 – Claim denied because this is not a work related injury/illness and thus not the liability of the workers' compensation carrier.
   - P2 – Not a work related injury/illness and thus not the liability of the workers' compensation carrier.

Issues

1. Did United Airlines, Inc. respond to the medical fee dispute?
2. Is the insurance carrier's denial of payment supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The Austin carrier representative for United Airlines, Inc. is Flahive Ogden & Latson. Flahive Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on June 12, 2019. Rule §133.307(d)(1) states that 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 carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. Pacific Billing Services, Inc. is seeking reimbursement for a designated doctor examination performed by Dr. Donnel Steuerwald on February 15, 2019. Available information finds that Dr. Steuerwald was ordered by the DWC to perform this examination.

   The insurance carrier is required to pay for a designated doctor examination ordered by the DWC, unless prohibited.[1] No evidence was presented that indicates the examination in question was prohibited. Therefore, the insurance carrier's denial of payment is not supported.

3. The submitted documentation supports that Dr. Steuerwald performed an evaluation of maximum medical improvement as ordered by the DWC. Therefore, the maximum allowable reimbursement for this examination is $350.00.[2]

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $350.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $350.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	September 13, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] Texas Labor Code §408.0041(h)
[2] 28 TAC §134.250(3)(C)

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.