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**
Donald G. Eaves, D.C.

**Respondent Name**
TPS Joint Self Insurance Funds

**MFDR Tracking Number**
M4-19-4478-01

**Carrier's Austin Representative**
Box Number 53

**MFDR Date Received**
June 11, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The report and billing were timely delivered to the adjuster listed on the DWC 32 form via fax on 01.12.2019 … a reconsideration was forwarded … on 05.01.2019 reflecting a copy of the fax confirmation for initial submission to the fax number listed on the TDI DWC 32 form for this evaluation."

**Amount in Dispute:** $800.00

## *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 |
|---|---|---|---|
| January 4, 2019 | Designated Doctor Examination | $800.00 | $800.00 |

## *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 (DWC).

**Background**

1. 28 Texas Administrative Code §133.240 sets out the procedures for submission of a medical bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired.

**Issues**

1. Did TPS Joint Self Insurance Funds respond to the medical fee dispute?
2. Is the insurance carrier's denial of payment for the examination in question supported?
3. Is Dr. Eaves entitled to additional reimbursement?

**Findings**

1. The Austin carrier representative for TPS Joint Self Insurance Funds is Hoffman Kelley LLP. The representative acknowledged receipt of the copy of this medical fee dispute on June 18, 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 insurance carrier or its representative. We therefore base this decision on the information available as authorized under 28 TAC §133.307(d)(1).

2. Dr. Eaves is seeking reimbursement for a designated doctor examination ordered by the DWC and performed on January 4, 2019. Per the explanation of benefits dated May 28, 2019, the insurance carrier denied reimbursement based on timely filing.

   The health care provider is required to submit a medical bill to the insurance carrier not less than 95 days after the date of service.[1] Dr. Eaves submitted a fax confirmation dated January 12, 2019, to the DWC as evidence of timely submission.

   The DWC concludes that the insurance carrier's denial of payment for the examination in question was not supported. This conclusion was based on the greater weight of evidence presented to the DWC.

3. Because the insurance carrier's denial of payment was not sufficiently supported, Dr. Eaves is entitled to reimbursement for the disputed examination.

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

   Review of the submitted documentation finds that Dr. Eaves performed impairment rating evaluations of right wrist and right knee. The MAR for the evaluation of the right wrist, a musculoskeletal body area performed with range of motion is $300.00.[3] The MAR for the evaluation of the right knee, a subsequent musculoskeletal body area is $150.00.[4] The total MAR for the determination of impairment rating is $450.00.

   The total allowable payment for the examination in dispute is $800.00. This amount is recommended.

**Conclusion**

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $800.00.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $800.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

[1] 28 TAC §133.240 (a) and (b)
[2] 28 TAC §134.250(3)(C)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[4] 28 TAC §134.250(4)(C)(ii)(II)(-b-)

**Authorized Signature**

| | | |
|---|---|---|
| | Laurie Garnes | October 9, 2019 |
| 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 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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**.