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
Troy Robinson, D.C.

Respondent Name
VF Corp

MFDR Tracking Number
M4-19-4582-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 20, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED"

Amount in Dispute: $650.00

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
December 13, 2018	Designated Doctor Examination	$650.00	$650.00

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 §133.307 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 and impairment rating.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information which is needed for adjudication. Add'l info is supplied using remittance advise remarks codes whenever appropriate.
   - Comments: "issues with tax id/ss number for vendor"
   - Comments: "SCANNED IN WITH WRONG TAX ID NUMBER WILL RE SCAN"

Issues

1. Did VF Corp respond to the medical fee dispute?
2. Is the insurance carrier's denial of payment supported?
3. Is Dr. Robinson entitled to reimbursement for the examination in question?

Findings

1. The Austin carrier representative for VF Corp is Flahive Ogden & Latson. The representative acknowledged receipt of the copy of this medical fee dispute on June 27, 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. Robinson is seeking reimbursement for a designated doctor examination ordered by the DWC to determine maximum medical improvement and impairment rating. The insurance carrier denied reimbursement based on missing or incorrect tax identification on the bill.

   The DWC finds that the copies of bills submitted to the DWC with this dispute include a tax identification number. The insurance carrier provided no information to support that this number was incorrect. Therefore, the DWC concludes that the insurance carrier's denial of payment for the examination in question is not supported.

3. Because the insurance carrier failed to support its denial of payment, Dr. Robinson is entitled to reimbursement.

   The submitted documentation supports that Dr. Robinson performed an evaluation of maximum medical improvement as ordered by the DWC. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.[1]

   The submitted documentation supports that Dr. Robinson provided an impairment rating of the left shoulder, a musculoskeletal body area, performing a full physical evaluation with range of motion. Reimbursement is $300.00 for this examination.[2]

   The total allowable reimbursement for the examination in dispute is $650.00. 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. 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 $650.00.

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 $650.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

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

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.