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
Laura Deon, M.D.

Respondent Name
Great Divide Insurance Company

MFDR Tracking Number
M4-19-5066-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 1, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "OUR OFFICE HAS SUBMITTED THIS CLAIM MULTIPLE TIMES AND EVERY TIME THE CARRIER HAS THE SAME RESPONSE. 'PLEASE RESUBMIT WITH A LEGIBLE OR UPRIGHT BILLING AS THE SUBMISSION IS ILLEGIBLE AND CANNOT BE PROCESS. A CLEAR COPY OF OUR SUBMISSION IS ATTACHED. WHEN WE REQUESTED A COPY OF THE SUBMISSION ON FILE THE CARRIER DID NOT RELEASE SAID REQUEST."

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Although the invoice had been returned for lack of a clear copy and not yet technically denied, I did plan to deny the invoice."

Response Submitted by: Berkley Entertainment

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 26, 2019	Examination to Determine Maximum Medical Improvement and Impairment Rating	$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.

Background

1. 28 Texas Administrative Code §133.200 sets out the procedures for receipt of a medical bill by the insurance carrier.
2. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

Issues

1. Did the insurance carrier raise a new defense in its response?
2. Is Dr. Deon entitled to reimbursement for the examination in question?

Findings

1. In its position statement, Berkley Entertainment, on behalf of the insurance carrier, argued that "Although the invoice had been returned for lack of a clear copy and not yet technically denied, I did plan to deny the invoice."

   The response from the insurance carrier is required to address only the denial reasons presented to the requestor the request for medical fee dispute resolution (MFDR) was filed with the Texas Department of Insurance, Division of Workers' Compensation (DWC). Any new denial reasons or defenses raised shall not be considered in this review.[1]

   No evidence was presented to the DWC that the bill was returned to Dr. Deon as incomplete.[2] The submitted documentation does not support that any denial was provided to Dr. Deon before this request for MFDR was filed. Therefore, the DWC will not consider the insurance carrier's argument in the current dispute review.

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

   Review of the submitted documentation finds that Dr. Deon performed impairment rating evaluations of the cervical spine with range of motion and a head injury. The MAR for the evaluation of the cervical spine, a musculoskeletal body area performed with range of motion is $300.00.[4] The MAR for the evaluation of the head, a non-musculoskeletal body area is $150.00.[5] The total MAR for the determination of impairment rating is $450.00.

   The total MAR for the examination in question is $800.00. This amount is recommended.

Conclusion

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.

Authorized Signature

	Laurie Garnes	September 10, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §133.307(d)(2)(F)
[2] 28 TAC §133.200
[3] 28 Texas Administrative Code §134.250(3)(C)
[4] 28 Texas Administrative Code §134.250(4)(C)(ii)(II)(-a-)
[5] 28 Texas Administrative Code §134.250(4)(D)(v)

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.