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
El Paso ISD

MFDR Tracking Number
M4-19-5068-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
August 1, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134. The carrier has not responded or has denied this claim in its entirety following our filing of Request for Reconsideration."

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
March 12, 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 payment or denial 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 submitted documentation does not include explanations of benefits.

Issues

1. Did El Paso ISD respond to the medical fee dispute?
2. Did the insurance carrier take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
3. Is Dr. Robinson entitled to reimbursement for the examination in question?

Findings

1. The Austin carrier representative for El Paso ISD is Downs Stanford PC. Downs Stanford PC acknowledged receipt of the copy of this medical fee dispute on August 8, 2019. 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.[1]

   As of today, no response has been received from the insurance carrier or its representative. We therefore base this decision on the information available.

2. Dr. Robinson is seeking reimbursement for a designated doctor examination to determine maximum medical improvement (MMI) and impairment rating (IR).

   Dr. Robinson argued that "CARRIER HAS YET TO AKNOWLEDGE THE CLAIM SUBMISSION AFTER MUTLIPLE ATTEMPTS." Evidence supports that Dr. Robinson submitted a bill for the examination to a fax number presented on the "Request for Designated Doctor Examination" (Form DWC032) on June 11, 2019.

   The insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information. [2]

   The greater weight of evidence presented to the DWC supports that a complete bill for the services in question was received by the insurance carrier or its agent. No evidence was provided to support that the insurance carrier took final action on the bill for the service in question.

3. Because the insurance carrier failed to defend a denial of payment for the examination in question, the DWC finds that 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. The maximum allowable reimbursement (MAR) for this examination is $350.00.[3]

   Review of the submitted documentation finds that Dr. Robinson performed impairment rating evaluations of the right shoulder, right wrist, and right hip. The MAR for the evaluation of the upper extremity, a musculoskeletal body area performed with range of motion, is $300.00.[4] The MAR for the evaluation of the lower extremity, a subsequent musculoskeletal body area, is $150.00.[5] The total MAR for the determination of impairment rating is $450.00.

   The total allowable reimbursement 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.

[1] 28 TAC §133.307(d)(1)
[2] 28 Texas Administrative Code §133.240(a)
[3] 28 TAC §134.250(3)(C)
[4] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[5] 28 TAC §134.250(4)(C)(ii)(II)(-b-)

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	October 30, 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.