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
Hartford Casualty Insurance Company

MFDR Tracking Number
M4-19-5118-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
August 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… the insurance carrier is required to take final action and send an EOB to the provider not later than the 45th day after receipt of the bill."

Amount in Dispute: $1,300.00

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 29, 2019	Designated Doctor Examination	$1,300.00	$1,300.00

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 medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine the ability of the injured employee to return to work.
4. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
5. The documentation submitted to the DWC does not include explanations of benefits.

Issues

1. Did Hartford Casualty Insurance Company respond to the medical fee dispute?
2. Did Hartford Casualty Insurance Company take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
3. Is Pacific Billing Services, Inc. entitled to additional reimbursement for the services in question?

Findings

1. The Austin carrier representative for Hartford Casualty Insurance Company is Burns, Anderson, Jury & Brenner, LP. Burns, Anderson, Jury & Brenner, LP received the copy of this medical fee dispute on August 14, 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 will base this decision on the information available.

2. Pacific Billing Services, Inc. is seeking reimbursement for a designated doctor examination performed by Dr. George Cole on March 29, 2019.

   Evidence supports that Pacific Billing Services, Inc. submitted a bill for the examination to fax number presented on the "Request for Designated Doctor Examination" (Form DWC032) on or about June 3, 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 Pacific Billing Services, Inc. is entitled to reimbursement.

   The submitted documentation supports that Dr. Cole 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. Cole performed impairment rating evaluations of the right shoulder and a traumatic brain injury. The MAR for the evaluation of the right shoulder, a musculoskeletal body area performed with range of motion is $300.00.[4] The MAR for the evaluation of a traumatic brain injury, a non-musculoskeletal body area, is $150.00.[5] The total MAR for the determination of impairment rating is $450.00.

   The submitted documentation indicates that Dr. Cole performed an examination to determine the ability of the injured employee to return to work. Therefore, the correct MAR for this examination is $500.00.[6]

   The total allowable reimbursement for the services in question is $1,300.00. 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 $1,300.00.

[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)(D)(v)
[6] 28 TAC §134.235

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 $1,300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	November 7, 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.