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
Casa View Chiropractic Clinic, Inc.

Respondent Name
Liberty Insurance Corporation

MFDR Tracking Number
M4-20-0045-01

Carrier's Austin Representative
Box Number 1

MFDR Date Received
September 9, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Liberty Mutual sent a payment of $400 with the explanation of the allowance is based on the value for services performed by a licensed non-physician. We talked to Liberty Mutual on 8-7-19 and explained that Dr. Blackwell was the designated doctor for this exam and according to the pay scale for this exam the fee is $500.00"

Amount in Dispute: $100.00

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
June 22, 2019	Designated Doctor Examination	$100.00	$100.00

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 §134.235 sets out the fee guidelines for examinations to determine the ability of the injured employee to return to work.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 252 – The recommended allowance is based on the value for services performed by a licensed non-physician practitioner.
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.

- W3 – Additional payment made on appeal/reconsideration.

Issues

1. Did Liberty Insurance Corporation respond to the medical fee dispute?
2. Is Casa View Chiropractic Clinic, Inc. entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Liberty Insurance Corporation is JT Parker & Associates, LLC. The representative received the copy of this medical fee dispute on September 17, 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. Casa View Chiropractic Clinic, Inc. is seeking additional reimbursement for a designated doctor examination to determine the injured employee's ability to return to work performed by Dr. Gilbert C. Blackwell on June 22, 2019.

   The submitted documentation supports that Dr. Blackwell performed the examination to determine the ability of the injured employee to return to work. Per 28 TAC §134.235, the maximum allowable reimbursement for this examination is $500.00. The insurance carrier paid $400.00. An additional $100.00 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 $100.00.

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 $100.00, 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 14, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §133.307(d)(1)

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.