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
PRUITT, ENAS LEE

Respondent Name
Mitsui Sumitomo Insurance USA, Inc.

MFDR Tracking Number
M4-20-0523-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 24, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and in compliance with TDI-DC Rule 133 and 134. The carrier has not responded or has denied this claim in its entirety following our filing of Request for Reconsideration. Therefore, we are filing for Medical Dispute Resolution at this time per DWC Rule 133.307."

Amount in Dispute: $1,100.00

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
January 8, 2019	Examination to Determine Maximum Medical Improvement and Impairment Rating	$1,100.00	$1,100.00

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 §133.240 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 documentation submitted to the DWC did not include explanations of benefits.

Issues

1. Did Mitsui Sumitomo Insurance USA, Inc. respond to the medical fee dispute?
2. Did Mitsui Sumitomo Insurance USA, Inc. take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
3. Is Dr. Pruitt entitled to additional reimbursement?

Findings

1. The Austin insurance carrier representative for Mitsui Sumitomo Insurance USA, Inc. is Flahive, Ogden & Latson. The representative received the copy of this medical fee dispute on October 31, 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. Dr. Pruitt is seeking reimbursement for a designated doctor examination to determine maximum medical improvement (MMI) and impairment rating (IR).

   Dr. Pruitt argued that the insurance did not respond to medical bills submitted for the examination in question. Evidence supports that Dr. Pruitt submitted a bill for the examination to the insurance carrier or its agent on or about March 6, 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. Pacific Billing is entitled to reimbursement for the examination in question because Space Exploration Technologies did not give a reason for not paying the billed amount.

   The evidence supports that Dr. Pruitt performed an evaluation of MMI. The reimbursement for this examination is $350.00.[3]

   The submitted narrative report indicates that Dr. Pruitt performed IR evaluations of the spine, bilateral upper extremities, bilateral lower extremities, and a head injury.

   The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[4] The MAR for the evaluation of subsequent musculoskeletal body areas are $150.00 each.[5] The MAR for the evaluation of a non-musculoskeletal body area is $150.00.[6]

[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §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-)
[6] 28 TAC §134.250(4)(D)(v)

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement	[redacted]		$350.00
IR: Bilateral Upper Extremities (ROM)	Musculoskeletal System	Upper Extremities	$300.00
IR: Cervical/Thoracic/Lumbar Spine (ROM)		Spine/Pelvis	$150.00
IR: Bilateral Lower Extremities (ROM)		Lower Extremities	$150.00
IR: Head Injury	Nervous System	Body Systems	$150.00
Total MMI	[redacted]		**$350.00**
Total IR			**$750.00**
Total Exam			**$1,100.00**

The total allowable reimbursement is $1,100.00. 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 $1,100.00.

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 $1,100.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	December 13, 2019 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.