



# TEXAS DEPARTMENT OF INSURANCE

## Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

PACIFIC BILLING

**Respondent Name**

New Hampshire Insurance Company

**MFDR Tracking Number**

M4-20-0922-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

December 13, 2019

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED. THE CURRENT RULES ALLOW REIMBURSEMENT."

**Amount in Dispute:** \$1,150.00

#### 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 18, 2019	Designated Doctor Examination	\$1,150.00	\$1,150.00

#### 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**

- 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of medical bills.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
- The DWC did not receive explanations of benefits with the submitted documentation.

## **Issues**

1. Did New Hampshire Insurance Company respond to the medical fee dispute?
2. Did New Hampshire 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 entitled to reimbursement for the examination in question?

## **Findings**

1. The Austin insurance carrier representative for New Hampshire Insurance Company is Flahive, Ogden & Latson. The representative received the copy of this medical fee dispute on December 19, 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.<sup>1</sup>

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 is seeking reimbursement for a designated doctor examination to determine maximum medical improvement (MMI), impairment rating (IR), and the ability to return to work. Pacific Billing argued that there was “No Response to Billing” for the examination in question.

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.<sup>2</sup>

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 submit any reason for denial of payment or evidence that payment was made, Pacific Billing is entitled to reimbursement for the examination in question.

The submitted documentation supports that Dr. Christopher Plate performed an evaluation of MMI as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is \$350.00.<sup>3</sup>

The submitted documentation supports that Dr. Plate provided an IR for a musculoskeletal body area, performing a full physical evaluation with range of motion of the left shoulder. Reimbursement is \$300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.<sup>4</sup>

The submitted documentation indicates that Dr. Plate performed an examination to determine the ability to return to work. The MAR for this examination is \$500.00.<sup>5</sup>

The total allowable reimbursement for the examination in question is \$1,150.00. 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 \$1,150.00.

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<sup>1</sup> 28 TAC §133.307(d)(1)

<sup>2</sup> 28 TAC §133.240 (a)

<sup>3</sup> 28 TAC §134.250(3)(C)

<sup>4</sup> 28 TAC §134.250(4)(C)(ii)(II)(-a-)

<sup>5</sup> 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 \$1,150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

_____	Laurie Garnes	January 29, 2020
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.**