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

Respondent Name
Truck Insurance Exchange

MFDR Tracking Number
M4-20-1411-01

Carrier's Austin Representative
Box Number 14

MFDR Date Received
February 6, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: $650.00

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
November 15, 2019	Designated Doctor Examination	$650.00	$650.00

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 §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. Texas Labor Code §408.0041 sets out the requirements for designated doctor examinations.
4. Texas Insurance Code §1305 sets out the requirements for certified health care networks.
5. The insurance carrier denied payment for the disputed examination based on network status.

Issues

1. Did Truck Insurance Exchange respond to the medical fee dispute?
2. Is the insurance carrier's denial based on network status supported?
3. Is Pacific Billing entitled to reimbursement for the examination in question?

Findings

1. The Austin insurance carrier representative for Truck Insurance Exchange is Farmers Insurance Group. The representative received the copy of this medical fee dispute on February 14, 2020. 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 is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating. The insurance carrier denied payment for the examination based on the claim's network status.

   Designated doctor examinations are ordered by the DWC and are not subject to network fee guidelines.[2] Unless otherwise prohibited, insurance carriers are liable for examinations ordered by the DWC.[3] Because the DWC ordered this examination under Texas Labor Code §408.0041, the insurance carrier's denial of payment is not supported.

3. The submitted documentation supports that Kirk Bradford, D.C. performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[4]

   The submitted documentation supports that Dr. Bradford provided an impairment rating of a musculoskeletal body area, performing a full physical evaluation with range of motion of the lumbar spine. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[5]

   Pacific Billing is entitled to a total reimbursement of $650.00. 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 $650.00.

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 $650.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

[1] 28 TAC §133.307 (d)(1)
[2] Texas Insurance Code §1305.003 (a)
[3] Texas Labor Code §408.0041 (h)(1)
[4] 28 TAC §134.250(3)(C)
[5] 28 TAC §134.250(4)(C)(ii)(II)(-a-)

Authorized Signature

	Laurie Garnes	XXX
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.