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
ROBERTSON, VALORIE

Respondent Name
STATE OFFICE OF RISK MANAGEMENT

MFDR Tracking Number
M4-20-2177-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
May 4, 2020

REQUESTOR'S POSITION SUMMARY

"DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED"

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

"To examine traumatic brain injuries, including concussion and post-concussion syndrome, a designated doctor must be board certified in neurological surgery, neurology, physical medicine and rehabilitation, or psychiatry by the ABMS or board certified in neurological surgery, neurology, physical medicine and rehabilitation, or psychiatry by the AOABOS.

Review of the Divisions TXCOMP system and the Texas Medical Board License verification system, Dr. Robertson's specialty is Family Medicine and is Certified by the American Board of Family Medicine. The Office determined that this provider was not eligible to perform this exam for Post-Concussion Syndrome pursuant to the Rules."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 28, 2019	Designated Doctor Examination	$500.00	$500.00

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, Chapter 127 sets out the procedures and requirements for designated doctors.
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 extent of the compensable injury.
4. Texas Labor Code §408.0041 sets out the requirements for designated doctor examinations.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.
   - P13 – Payment reduced or denied based on workers' compensation jurisdictional regulations or payment policies, use only if no other code is applicable.
   - Notes: "It has been determined that the examining doctor is not qualified to perform this exam."

Issues

1. Are State Office of Risk Management's reasons for denial of payment supported?
2. Is Valorie Robertson, M.D. entitled to reimbursement for the examination in question?

Findings

1. Dr. Robertson is seeking reimbursement for a designated doctor examination for the sole purpose of determining if the extent of the compensable injury included post-concussive syndrome.

   The insurance carrier denied payment, in part, saying, "This provider is not certified/eligible to be paid for this procedure/service on this date of service." Dr. Robertson was certified as a designated doctor from August 7, 2018, through August 7, 2020.

   State Office of Risk Management also denied payment saying that "the examining doctor is not qualified to perform this exam."

   The DWC may exempt a designated doctor from the applicable qualification standard if no other designated doctor is qualified and available to perform the examination.[1] Dr. Robertson received an order from the Commissioner of the Division of Workers' Compensation dated October 2, 2019, to perform a designated doctor examination to determine the extent of the compensable injury.

   On October 14, 2019, State Office of Risk Management requested an expedited contested case hearing (CCH) and stay of examination. On the same day, the DWC granted the request for the CCH, but denied the stay of examination, as the request was not timely. Dr. Robertson complied with the *Commissioner Order* to perform the examination in question.

   The DWC concludes that State Office of Risk Management was not relieved of reimbursement for the examination performed. The insurance carrier's denial of payment is not supported.

2. Because the insurance carrier failed to support its denial of payment, the DWC finds that Dr. Robertson is entitled to reimbursement for the examination in question.

   The maximum allowable reimbursement for an examination to determine the extent of the compensable injury is $500.00.[2] 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 $500.00.

[1] 28 TAC §127.130 (d)

[2] 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 $500.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July 20, 2021
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.