



**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**

ROBILLARD, STEVEN THOMAS

**Respondent Name**

NATIONAL UNION FIRE INS CO OF PITTSB PA

**MFDR Tracking Number**

M4-21-1154-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

March 8, 2021

**REQUESTOR'S POSITION SUMMARY**

Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of adjudication.

**Amount in Dispute:** \$650.00

**RESPONDENT'S POSITION SUMMARY**

"... we have escalated the bills in question for manual review to determine if additional monies are owed."

**Response Submitted by:** Gallagher Bassett

**SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 15, 2020	Designated Doctor Examination (99456-W5-WP)	\$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 §133.240 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 submitted documentation did not include explanations of benefits.

**Issues**

1. Did the insurance carrier take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
2. Is Steven Robillard, D.C. entitled to reimbursement for the examination in question?

**Findings**

1. Dr. Robillard is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating.

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>1</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.

2. Because the insurance carrier failed to provide any defense for non-payment of the designated doctor examination in question, Dr. Robillard is entitled to reimbursement.

The submitted documentation supports that Dr. Robillard performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement for this examination is \$350.00.<sup>2</sup>

The submitted documentation supports that Dr. Robillard provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the right knee. Reimbursement is \$300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.<sup>3</sup>

The total allowable amount for the examination in question is \$650.00. 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. Though all the evidence may not have been discussed, it was considered. 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.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

June 9, 2021  
\_\_\_\_\_  
Date

<sup>1</sup> 28 TAC §133.240 (a)

<sup>2</sup> 28 TAC §134.250(3)(C)

<sup>3</sup> 28 TAC §134.250(4)(C)(ii)(II)(-a-)

### ***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.**