



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

Valorie Robertson, M.D.

Respondent Name

Great Midwest Insurance Company

MFDR Tracking Number

M4-18-1688-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

January 29, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED"

Amount in Dispute: \$1,965.00

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
September 19, 2017	Designated Doctor Examination	\$1,965.00	\$1,950.00

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.

Background

- 28 Texas Administrative Code §130.1 sets out the documentation requirements for reports of maximum medical improvement and impairment rating.
- 28 Texas Administrative Code §133.210 sets out the documentation requirements for medical bills.
- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations of extent of injury and return to work.
- 28 Texas Administrative Code §134.239 addresses the billing of work status reports with division-ordered examinations.
- 28 Texas Administrative Code §134.240 sets out the fee guidelines for designated doctor examinations.
- 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 252 – An attachment/other documentation is required to adjudicate this claim/service.
 - 5567 – Payment denied, pending receipt of medical records with copy of bill attached.

Issues

1. Did Great Midwest Insurance Company (GMIC) respond to the medical fee dispute?
2. Is the insurance carrier's reason for denial of payment supported?
3. Is Valorie Roberson, M.D. entitled to reimbursement for the services in dispute?

Findings

1. The Austin carrier representative for GMIC is Flahive, Ogden & Latson. The carrier representative acknowledged receipt of the copy of this medical fee dispute on February 6, 2018. The response to a medical fee dispute from the insurance carrier is due within 14 days of the receipt of the dispute.¹

Review of the information submitted information finds that no response has been received on behalf of GMIC from Flahive, Ogden & Latson to date. The division concludes that GMIC failed to respond within the required timeframe. For that reason the division will base its decision on the information available.

2. Dr. Robertson is seeking reimbursement for a designated doctor examination as ordered by the division performed on September 19, 2017. The insurance carrier is required to reimburse an examination ordered by the division unless it has been prohibited.

The insurance carrier denied the disputed examination due to lack of documentation, specifically medical records.

Dr. Robertson was required to submit a narrative and related reports with the medical bill in question to the insurance carrier,² unless it had been provided to the insurance carrier before submission of the bill.³

In its request for reconsideration of the medical bill, Genesis Medical Management Solutions stated on behalf of Dr. Robertson that it included "a copy of the original claim/bill and required medical documentation **as originally submitted** [emphasis added]." Fax confirmation provided indicates that the report was submitted to the adjuster via the fax number included on the Request for Designated Doctor Examination, which was submitted by the adjuster, Simone Baker.

The division considers any billing information or documentation that the insurance carrier or its agent has to be possessed by both, because it is the insurance carrier's responsibility to ensure that its agents have all the documentation needed to resolve a medical bill.⁴

The division concludes that the narrative and related reports were submitted to the insurance carrier with the medical bill as required. The division finds that the denials for this reason are not supported.

3. Because GMIC did not support its denial of payment for the disputed services, Dr. Robertson is eligible for reimbursement. The division calculates the maximum allowable reimbursement (MAR) as follows:

The MAR for determining maximum medical improvement is \$350.00.⁵ The MAR for determining the impairment rating of each body area is \$300.00 for the first musculoskeletal body area when range of motion testing is performed, \$150.00 for each additional musculoskeletal body area, and \$150.00 for non-musculoskeletal body areas.⁶ Dr. Robertson's records indicate that she performed range of motion testing and provided impairment ratings for the spine, right arm, both legs, and the face. For this reason the MAR for this examination is \$750.00.

¹ 28 Texas Administrative Code §133.307(d)(1)

² 28 Texas Administrative Code §130.1(d)(2)

³ 28 Texas Administrative Code §133.210(b)

⁴ 28 Texas Administrative Code §133.210(e)

⁵ 28 Texas Administrative Code §134.250(3)

⁶ 28 Texas Administrative Code §134.250(4)

The MAR for other examinations performed by designated doctors is \$500.00 for the first examination and \$250.00 for the next examination.⁷ Dr. Robertson performed examinations to determine the extent of the compensable injury and the injured employee's ability to return to work. The total MAR for these examinations is \$750.00.

Dr. Robertson also filed a Work Status Report, requesting reimbursement of \$15.00 for this form. This form is not reimbursable when it is filed with a designated doctor examination.⁸

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement			\$350.00
IR: Cervical Spine (ROM)	Musculoskeletal System	Spine and Pelvis	\$300.00
IR: Lumbar Spine (ROM)			
IR: Right Elbow (ROM)	Musculoskeletal System	Upper Extremities	\$150.00
IR: Knees (ROM)	Musculoskeletal System	Lower Extremities	\$150.00
IR: Face Contusion	Skin	Body Structures	\$150.00
Total MMI			\$350.00
Total IR			\$750.00
Multiple IR Calculations x 2			\$100.00
Extent of Injury			\$500.00
Return to Work			\$250.00
Work Status Report			\$0.00
Total Exam			\$1,950.00

The total MAR for the disputed services is \$1,950.00. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,950.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$1,950.00, 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

September 12, 2018
Date

⁷ 28 Texas Administrative Codes §§134.235 and 134.240(2)

⁸ 28 Texas Administrative Code §134.239

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 division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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.