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 Services, Inc.

Respondent Name
TPCIGA for Lumbermens Mutual Casualty Company

MFDR Tracking Number
M4-19-4388-01

Carrier's Austin Representative
Box Number 50

MFDR Date Received
June 5, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THIS IS A DDE TO DETERMINE EOI – YOUR DENIAL IS NOT VALID"

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "TPCIGA has reviewed the dispute and find that the bill in question was disputed based on extent of injury. Please see PLN-11 attached."

Response Submitted by: Texas Property & Casualty Insurance Guaranty Association

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 3, 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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine the extent of the compensable injury.
3. Texas Labor Code §408.0041 provides the authority of designated doctors to address certain questions.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 219 – Based on extent of injury
   - 247 – A payment or denial has already been recommended for this service.
   - 18 – Exact duplicate claim/service.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Pacific Billing Services, Inc., billing agent for Richard Lawrence, M.D., is seeking reimbursement for a designated doctor examination to determine the extent of the compensable injury. The insurance carrier denied reimbursement for this examination based on the extent of the compensable injury.

Available documentation supports that Dr. Lawrence performed this examination based on an order by the commissioner of the DWC.[1] Therefore, this examination is not subject to denial based on the extent of the compensable injury.

The maximum allowable reimbursement for an examination to determine the extent of a compensable injury is $500.00.[2] The DWC concludes that Pacific Billing Services, Inc. is entitled to reimbursement of this amount.

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.

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

	Laurie Garnes	July 23, 2019
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 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.

[1] Texas Labor Code §408.0041(a)

[2] 28 Texas Administrative Code §134.235