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
CHARTWELL MEDICAL SOLUTION INC

Respondent Name
El Paso ISD

MFDR Tracking Number
M4-20-0094-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
September 13, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "**Determine maximum medical improvement & impairment rating Exam $350.00 + Body Area $150.00 DRE Method** (Reimbursement $500.00) … **Employee's ability to return to work** (Reimbursement $500.00) **Total Reimbursement $1000.00**"

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin insurance carrier representative for El Paso ISD is Downs-Stanford, PC. The representative received the copy of this medical fee dispute on September 20, 2019. 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, we have not received from the insurance carrier or its representative. We will base this decision on the information available.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 9, 2019	Required Medical 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).

[1] 28 TAC §133.307(d)(1)

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 ability to return to work.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

Issues

Is Chartwell Medical Solutions, Inc. entitled to additional reimbursement?

Findings

Chartwell Medical Solutions, Inc. is seeking reimbursement for a required medical examination requested by the insurance carrier. El Paso ISD reduced the payment citing fee guidelines.

The submitted documentation supports that Benson Chee, M.D. performed an evaluation of maximum medical improvement as requested by the insurance carrier. The maximum allowable reimbursement (MAR) for this examination is $350.00.[2]

The submitted documentation supports that Dr. Chee provided an impairment rating of the spine, using the DRE Method. Reimbursement is $150.00 for this examination.[3]

The submitted documentation indicates that Dr. Chee performed an examination to determine the injured employee's ability to return to work as requested by the insurance carrier. The MAR for this examination is $500.00.[4]

The total allowed amount is $1000.00. The insurance carrier paid $350.00. An additional $650.00 is recommended.

Conclusion

Based on the information available, 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

	Laurie Garnes	December 13, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[2] 28 TAC §134.250(3)(C)
[3] 28 TAC §134.250(4)(C)(ii)(I)
[4] 28 TAC §134.235

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.