



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

Yuemeng Dai, M.D.

Respondent Name

Arch Indemnity Insurance Company

MFDR Tracking Number

M4-20-0260-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

September 27, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THIS CLAIM HAS BEEN SUBMITTED TO THE CARRIER MULTIPLE TIMES, WITH NO VALID RESPONSE. BOTH PROOF OF SUBMISSIONS ARE ATTACHED."

Amount in Dispute: \$350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per fee schedule review, the bill denied correctly ... Denial explanation - Date(s) of service exceed time period for submission per Rul 133.20(b) and-or 133.250(b) ... Denial is a GB specific rule/denial. Timely filing rule for GB TX bills."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: December 1, 2018, Designated Doctor Examination, \$350.00, \$350.00

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 medical bills.
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. No explanations of benefits were submitted with this dispute.

**Issues**

1. Did the insurance carrier raise a new defense in its response?
2. Is Dr. Yuemeng Dai entitled to reimbursement for the examination in question?

**Findings**

1. In its position statement, Gallagher Bassett, on behalf of the insurance carrier, argued that “the bill denied correctly ... Date(s) of service exceed time period for submission.”

The response from the insurance carrier is required to address only the denial reasons presented to the requestor the request for medical fee dispute resolution (MFDR) was filed with the Texas Department of Insurance, Division of Workers’ Compensation (DWC). Any new denial reasons or defenses raised shall not be considered in this review.<sup>1</sup>

No evidence was submitted to support that any denial reason was provided to Dr. Yuemeng Dai before this request for MFDR was filed. Therefore, the DWC will not consider this argument in the current dispute review.

2. Dr. Yuemeng Dai is seeking reimbursement for a designated doctor examination performed on December 1, 2018. Because the insurance carrier did not support its denial of payment, the doctor is entitled to reimbursement.

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

**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 \$350.00.

***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 \$350.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

	Laurie Garnes	October 30, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

<sup>1</sup> 28 Texas Administrative Code §133.307(d)(2)(F)  
<sup>2</sup> 28 TAC §134.250(3)(C)

### ***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.**