



# 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**

PACIFIC BILLING

**Respondent Name**

XL Insurance America, Inc.

**MFDR Tracking Number**

M4-20-0319-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

October 2, 2019

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

**Amount in Dispute:** \$1,100.00

### 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
April 5, 2019	Designated Doctor Examination	\$1,100.00	\$1,100.00

### 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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. The documents submitted to the DWC do not include explanations of benefits.

## Issues

1. Did XL Insurance America, Inc. respond to the medical fee dispute?
2. Did XL Insurance America, Inc. take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
3. Is Pacific Billing entitled to additional reimbursement?

## Findings

1. The Austin insurance carrier representative for XL Insurance America, Inc. is Flahive, Ogden & Latson. The representative received the copy of this medical fee dispute on October 9, 2019. If the DWC does not get a response within 14 days of the dispute notice, the DWC can decide using the available information.<sup>1</sup>

As of today, the DWC has not received a response from the insurance carrier or its representative. We will base this decision on the information available.

2. Pacific Billing is seeking reimbursement for a designated doctor examination to determine maximum medical improvement (MMI) and impairment rating (IR).

A document submitted with the request for MFDR stated “No Response To Billing.” Evidence supports that Pacific Billing submitted a bill for the examination to the insurance carrier or its agent on or about April 18, 2019, and June 14, 2019.

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>2</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.

3. Pacific Billing is entitled to reimbursement for the examination in question because XL Insurance America, Inc. did not give a reason for not paying the billed amount.

The evidence supports that Charles Tuen, M.D. performed an evaluation of MMI as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is \$350.00.<sup>3</sup> The DWC recommends this amount.

The designated doctor’s report indicates that Dr. Tuen performed IR evaluations of a puncture wound of the right hand, cervical strain, lumbar strain, right thoracic contusion, right shoulder sprain, right wrist sprain, and right elbow contusion and sprain, right hip, and right ankle sprain.

The MAR for the evaluation of a musculoskeletal body area performed with range of motion is \$300.00.<sup>4</sup> The MAR for the evaluation of a musculoskeletal body area determined using the DRE method is \$150.00.<sup>5</sup> The MAR for the evaluation of subsequent musculoskeletal body areas is \$150.00 each.<sup>6</sup> The MAR for the evaluation of a non-musculoskeletal body area is \$150.00.<sup>7</sup>

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<sup>1</sup> 28 TAC §133.307(d)(1)

<sup>2</sup> 28 TAC §133.240 (a)

<sup>3</sup> 28 TAC §134.250(3)(C)

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

<sup>5</sup> 28 TAC §134.250(4)(C)(ii)(I)

<sup>6</sup> 28 TAC §134.250(4)(C)(ii)(II)(-b-)

<sup>7</sup> 28 TAC §134.250(4)(D)(v)

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement			\$350.00
IR: Right Shoulder, Wrist, Elbow (ROM)	Musculoskeletal System	Upper Extremities	\$300.00
IR: Cervical/Lumbar Spine (DRE)		Spine/Pelvis	\$150.00
IR: Right hip, ankle (ROM)		Lower Extremities	\$150.00
IR: Right Hand Puncture Wound, Right Thoracic Contusion	Skin	Body Structures	\$150.00
<b>Total MMI</b>			<b>\$350.00</b>
<b>Total IR</b>			<b>\$750.00</b>
<b>Total Exam</b>			<b>\$1,100.00</b>

The total MAR for the determination of impairment rating is \$1,100.00.

**Conclusion**

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. 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 \$1,100.00.

**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 \$1,100.00, 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

December 12, 2019  
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 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.**