



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

Respondent Name

El Paso ISD

MFDR Tracking Number

M4-20-0657-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

November 8, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "MMI = \$350.00
IR - W/ROM = \$300.00
TTL = \$650.0"

Amount in Dispute: \$300.00

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

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 19, 2019, Designated Doctor Examination, \$300.00, \$300.00

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 insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
- 309 - The charge for this procedure exceeds the fee schedule allowance.
- 4150 - An allowance has been paid for a designated doctor examination as outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was a

- P12 – Workers’ compensation jurisdictional fee schedule adjustment.

Issues

1. Did El Paso ISD respond to the medical fee dispute?
2. Is Pacific Billing entitled to additional reimbursement?

Findings

1. The Austin insurance carrier representative for El Paso ISD is Downs Stanford. The representative received the copy of this medical fee dispute on November 19, 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, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. Pacific Billing 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 Karen Clark-Singh, D.C. performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is \$350.00.²

The submitted documentation supports that Dr. Clark-Singh provided an impairment rating of the right upper extremity, performing an examination that included range of motion. Reimbursement is \$300.00 for this examination.³

The total allowable reimbursement is \$650.00. The insurance carrier paid \$350.00. An additional reimbursement of \$300.00 is recommended.

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 \$300.00.

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 \$300.00, 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

January 6, 2020
Date

¹ 28 TAC §133.307(d)(1)

² 28 TAC §134.250(3)(C)

³ 28 TAC §134.250(4)(C)(ii)(I)

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.