



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

ACIG INSURANCE CO

MFDR Tracking Number

M4-20-0924-01

Carrier's Austin Representative

Box Number 47

MFDR Date Received

December 13, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CURRENT RULES ALLOW FOR REIMBURSEMENT"

Amount in Dispute: \$1,150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In light of the additional file material that was included in Pacific Billings' MFDR request, ACIG will reprocess this claim in accordance with the Division Rules."

Response Submitted by: Burns, Anderson, Jury & Brenner, LLP

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 1, 2019	Designated Doctor Examination	\$1,150.00	\$1,150.00

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 §134.235 sets out the fee guidelines for examinations to determine 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

1. Did ACIG Insurance Company maintain its denial of the disputed services?
2. Is Pacific Billing entitled to reimbursement for the services in question?

Findings

1. Pacific Billing is seeking reimbursement for a designated doctor examination performed July 1, 2019. In its position statement, Burns, Anderson, Jury & Brenner, LLP stated “In light of the additional file material that was included in Pacific Billings’ MFDR request, ACIG will reprocess this claim in accordance with the Division Rules.”

The DWC finds that the insurance carrier did not maintain its denial of payment for the disputed services.

2. In an email dated April 2, 2020, Pacific Billing stated that no payment had been received. The insurance carrier has provided no evidence that payment has been made for the services in question. Therefore, the DWC finds that Pacific Billing is entitled to reimbursement for these services.

The submitted documentation supports that Martin Jones, M.D. performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is \$350.00.¹

The submitted documentation supports that Dr. Jones provided an impairment rating of the right knee, a musculoskeletal body area, performing a full physical evaluation with range of motion. Reimbursement is \$300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.²

The submitted documentation indicates that Dr. Jones performed an examination to determine the injured employee’s ability to return to work. The MAR for this examination is \$500.00.³

The total allowable reimbursement for the services in question is \$1,150.00. This amount 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 \$1,150.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$1,150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 22, 2020 Date
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¹ 28 TAC §134.250 (3)(C)

² 28 TAC §134.250 (4)(C)(ii)(II)(-a-)

³ 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.