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
Elite Healthcare North Dallas

Respondent Name
Employers Preferred Ins Co

MFDR Tracking Number
M4-21-0890-01

Carrier's Austin Representative
Box Number 4

MFDR Date Received
February 1, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…99361-W1 should be reimbursed at the allowed amount of $113 per TDI's Medical Fee Guideline."

Amount in Dispute: $85.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Austin carrier representative for Employers Preferred Ins Co is the law office of Ricky Green who was notified of this medical fee dispute on February 9, 2021. Rule §133.307(d)(1) states that if the division does not receive the response within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 6, 2020	99361-W	$85.00	$0.00

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.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 details the medical fee guideline for workers' compensation specific

services.

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
   - P12 – Workers' compensation jurisdictional fee schedule adjustment

Issues

Did the insurance carrier reimburse in accordance to applicable fee guideline?

Findings

The requestor states in their position statement "99361-W1 should be reimbursed at the allowed amount of $113 per TDI's Medical Fee Guideline." 28 TAC 134.204 (e)(4)(A)(ii) states in pertinent part reimbursement to the referral HCP shall be $28 when a HCP contributes to the case management activity.

Review of the submitted medical bill found the requestor was Elite Health Care North Dallas. Per the rule shown above the health care provider is reimbursed $28.00. The insurance company paid $28.00. No additional reimbursement is due.

Conclusion

In resolving disputes over reimbursement for medically necessary health care to treat a compensable injury, the role of DWC is to adjudicate payment following Texas laws and DWC rules. The findings in this decision are based on the evidence available at the time of review. Even though not all the evidence was discussed, it was considered.

For the reasons above the requestor has not established payment is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	April 16, 2021 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.