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
SERVICE LLOYDS INSURANCE CO

MFDR Tracking Number
M4-21-1742-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
June 2, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS"

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The previous review is being maintained (Payment of $0) and no additional allowance is recommended as the billed diagnoses are compensable. However, the diagnoses treated per the attached medical report includes [redacted]. This diagnosis was deemed not compensable per PLN11 dispute on file."

Response Submitted by: Mitchell International, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 14, 2021	Designated Doctor Examination (99456-W5-NM)	$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 §127.10 sets out the requirements for designated doctor examinations.
2. 28 Texas Administrative Code §130.1 sets out the authorization for performing examinations to determine maximum medical improvement and impairment rating.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
5. Texas Labor Code §408.0041 sets out the requirements for designated doctor examinations.

6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 219 – Based on extent of injury.
   - 375 – Please see special *NOTE* below.
   - 751 – Extent of injury not finally adjudicated
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - Note: "The DD was to address MMI/IR only. RTCT are disputed."

Issues

1. Is the examination in question subject to dismissal based on extent of injury?
2. Is Pacific Billing entitled to reimbursement for the examination in question?

Findings

1. Pacific Billing is seeking reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating ordered by the DWC. Service Lloyds Insurance Company denied payment based on the extent of the compensable injury.

   The insurance carrier is required to reimburse designated doctor examinations unless otherwise prohibited by statute, order, or rule.[1] The insurance carrier submitted no evidence to support that reimbursement for the examination in question was prohibited. The DWC finds that the examination in question is not subject to dismissal based on extent of injury.

2. Because the insurance carrier did not support its denial of payment, Pacific Billing is entitled to reimbursement.

   The submitted documentation supports that Dean Rushing, 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] This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered. For the reasons stated above, the Texas Department of Insurance, Division of Workers' Compensation (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

Signature	Medical Fee Dispute Resolution Officer	July 20, 2021 Date

[1] TLC §408.0041 (h)

[2] 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 division 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.