TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name
Masha Barenbaum, M.D.

Respondent Name
Ace American Insurance Co.

MFDR Tracking Number
M4-25-1864-01

Carrier's Austin Representative
Box Number 15

DWC Date Received
April 14, 2025

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 16, 2024	01830 AA	$474.67	$0.00

Requester's Position

"The carrier has provided a copy of a Review Analysis for our claim, but we have not received the payment that they have indicated they issued to the provider."

Amount in Dispute: $474.67

Respondent's Position

"The bill related to the above captioned MDR has been paid."

Response Submitted by: ESIS

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code (TLC) §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) §133.305 sets out the procedures for resolving medical disputes.

2. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 1 – Charge exceeds Fee Schedule allowance (222)
- 2 – P12 – Workers compensation jurisdictional fee schedule adjustment. (ANSIP12)
- 3 – A technical Bill Review (TBR) has been performed. (ETBR)

Issues

1. Is Masha Barenbaum, M.D. entitled to additional reimbursement?

Findings

1. Dr. Barenbaum is seeking reimbursement of $474.67 for anesthesia services provided on October 16, 2024. The requester has submitted this request in accordance with 28 TAC §133.305, which defines a medical fee dispute, in relevant part as

   (4) … a dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury … The following types of disputes can be a medical fee dispute:

   (A) a health care provider, or a qualified pharmacy processing agent as described in Labor Code §413.0111, dispute of an insurance carrier reduction or denial of a medical bill;

   (B) an injured employee dispute of reduction or denial of a refund request for health care charges paid by the injured employee; and

   (C) a health care provider dispute regarding the results of a division or insurance carrier audit or review which requires the health care provider to refund an amount for health care services previously paid by the insurance carrier.

   The evidence submitted to DWC indicates that the insurance carrier paid the requester the amount sought by Dr. Barenbaum in this dispute. No additional reimbursement is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requester

and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requester is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July 25, 2025
Signature	Medical Fee Dispute Resolution Officer	Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option three or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1 (d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción tres o correo electronico CompConnection@tdi.texas.gov.