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
Jack P. Mitchell, D.C.

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-18-1063-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
December 11, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "For this exam … MMI was first determined and an impairment rating was calculated for one (1) musculoskeletal body area using a DRE for lumbar spine. The provider should be reimbursed for First determining MMI for $350.00, then Secondly for a DRE to spine at $150.00 for a total of $500.00 … code 99456-WP-W6 Represents non-MMI/IR by DD … As … billed on HCFA 1500 indicated on Box 24 and identified by modifier W6 is a non-MMI/IR for $500.00 which was ordered by the TDI/DWC … Since the extent of injury was part of the DDE, it is reasonable to have multiple impairments indicated on separate Reports of Medical Evaluations (DWC-69) taking into account various combinations of extent diagnosis. This was performed as requested."

Amount in Dispute: $400.00

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

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 5, 2017	Designated Doctor Examination	$400.00	$400.00

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 §134.235 sets out the fee guidelines for examinations to determine the extent of the compensable injury.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum

medical improvement and impairment ratings.

4. 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

1. Did the State Office of Risk Management (SORM) respond to the medical fee dispute?
2. Is Jack P. Mitchell, D.C. entitled to additional reimbursement?

Findings

1. SORM acknowledged receipt of the copy of this medical fee dispute on December 19, 2017. 28 Texas Administrative Code §133.307 states, in relevant part:

   (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
   (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

   Review of the documentation finds that no response has been received on behalf of SORM to date. The division concludes that SORM failed to respond within the timeframe required by §133.307(d)(1). For that reason the division will base its decision on the information available.

2. Dr. Mitchell is seeking additional reimbursement for a designated doctor examination performed on October 5, 2017.

   The maximum allowable reimbursement (MAR) for a determination of maximum medical improvement and impairment rating for one musculoskeletal body area determined by the DRE method is $500.00 in accordance with 28 Texas Administrative Code §134.250(3)(C) and (4)(C)(ii)(I). SORM reimbursed $350.00. An additional $150.00 is recommended for this service.

   The MAR for a designated doctor examination to determine the extent of the compensable injury is $500.00 in accordance with 28 Texas Administrative Code §134.235. SORM reimbursed $300.00. An additional reimbursement of $200.00 is recommended for this service.

   The MAR for multiple impairment ratings is $50.00 per calculation. Dr. Mitchell's billing indicates that two additional calculations were provided. The division finds that the total allowable for this service is $100.00. SORM reimbursed $50.00. An additional $50.00 is recommended.

   The division finds that an additional reimbursement totaling $400.00 is recommended for the services in question.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $400.00.

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 $400.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	July 13, 2018
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 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 division 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.