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
Jack P. Mitchell, D.C.

Respondent Name
El Paso ISD

MFDR Tracking Number
M4-19-5023-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
July 29, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "For this exam, and as clearly indicated in the attached report, MMI was first determined then an impairment was calculated for one (1) separate musculoskeletal body area, using a full physical evaluation with range of motion for the upper extremity."

Amount in Dispute: $300.00

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
April 18, 2019	Designated Doctor Examination	$300.00	$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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 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.
   - 4150 – An allowance has been paid for a designated doctor examination as outline in 134.204(j) for attainment of maximum medical improvement. An additional allowance may be payable if a determination of the impairment caused by the compensable injury was a
   - Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Did El Paso ISD respond to the medical fee dispute?
2. Is Dr. Mitchell entitled to additional reimbursement for the examination in question?

Findings

1. The Austin carrier representative for El Paso ISD is Downs Stanford PC. Downs Stanford PC acknowledged receipt of the copy of this medical fee dispute on August 6, 2019. If the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.[1]

   As of today, no response has been received from the insurance carrier or its representative. We therefore base this decision on the information available.

2. Dr. Mitchell is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement (MMI) and impairment rating (IR). The insurance carrier reduced the reimbursement to $350.00 citing the fee guidelines.

   Dr. Mitchell argued that "MMI was first determined then an impairment was calculated for one (1) separate musculoskeletal body area, using a full physical evaluation with range of motion for the upper extremity."

   The maximum allowable reimbursement (MAR) for an examination to determine maximum medical improvement is $350.00.[2] Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[3]

   No evidence was presented to support that Dr. Mitchell performed the services in question. No additional reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has not established that additional reimbursement 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 DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	November 8, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §134.250(3)(C)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-a-)

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.