TEXAS DEPARTMENT OF INSURANCE
**Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)**
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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# MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

## *GENERAL INFORMATION*

**Requestor Name**
Jack P. Mitchell, D.C.

**Respondent Name**
Accident Fund Insurance Company of America

**MFDR Tracking Number**
M4-19-5260-01

**Carrier's Austin Representative**
Box Number 6

**MFDR Date Received**
August 23, 2019

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "The insurance carrier does not have a valid reason for reducing this claim as billed and owes the provider an additional $50.00. The Insurance Carrier EOB indicated the amount to pay correctly but the check was less $50.00. Possibly a clerical error."

**Amount in Dispute:** $50.00

## *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 |
|---|---|---|---|
| May 16, 2019 | Designated Doctor Examination | $50.00 | $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:
   - 18 – Exact duplicate claim/service
   - 247 – A payment or denial has already been recommended for this service
   - D1 – Duplicate Control Number 20772

**Issues**

1. Did the insurance carrier respond to the medical fee dispute?
2. Is Dr. Mitchell entitled to additional reimbursement?

**Findings**

1. The Austin carrier representative for Accident Fund Insurance Company of America is Stone Loughlin & Swanson, LLP. Stone Loughlin & Swanson, LLP received the copy of this medical fee dispute on August 30, 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 will base this decision on the information available.

2. Dr. Mitchell is seeking additional reimbursement of $50.00 for a designated doctor examination performed on May 16, 2019. Dr. Mitchell indicated that an explanation of benefits was received that "indicated the amount to pay correctly but the check was less $50.00." This explanation of benefits was not presented to the DWC for evaluation.

   The DWC has evaluated this dispute with the information provided and finds that no further 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 7, 2019 |
|---|---|---|
| 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 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**.

[1] 28 TAC §133.307(d)(1)