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**
BOOKER, SHELLEY

**Respondent Name**
TRAVELERS COMPANIES INC

**MFDR Tracking Number**
M4-20-1864-01

**Carrier's Austin Representative**
Box Number 05

**MFDR Date Received**
April 3, 2020

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Per DWC rules $500 should be paid for an assessment of extent of injury."

**Amount in Dispute:** $500.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The Carrier has previously paid the amount in dispute prior to the Provider filing this Request for Medical Fee Dispute Resolution."

**Response Submitted by:** Travelers

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| January 29, 2020 | Designated Doctor Examination | $500.00 | $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). 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

**Issues**

Is Shelley Booker, D.C. entitled to additional reimbursement?

**Findings**

Dr. Booker is seeking an additional $500.00 for a designated doctor examination to determine the extent of the compensable injury. Per documentation submitted by the insurance carrier, this amount was paid on or about March 28, 2020, via check number [redacted]. No additional reimbursement can be recommended.

**Conclusion**

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. 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**

| | | |
|---|---|---|
| | | June 2, 2020 |
| 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**.