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
MITCHELL, JACK PAUL JR

Respondent Name
OLD REPUBLIC INSURANCE CO

MFDR Tracking Number
M4-21-0143-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
September 29, 2020

REQUESTOR'S POSITION SUMMARY

"The narrative report describes how and why the examinee was not at MMI. In accordance with TDI/DWC rule, the examining doctor shall be reimbursed $350.00 for MMI evaluation, and also receive an additional $100.00 reimbursement for two separate Impairment calculations."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

"… we have escalated the bills in question for manual review to determine of additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 16, 2020	Designated Doctor Examination – Multiple Impairments (99456-WP-MI)	$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. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 00223 – Workers' compensation jurisdictional fee schedule adjustment.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 5853 – The amount paid reflects a fee schedule reduction.

Issues

Is Jack P. Mitchell, Jr., D.C. entitled to additional reimbursement for the service in question?

Findings

Dr. Mitchell is requesting additional reimbursement for additional impairment calculations as part of a designated doctor examination performed on July 16, 2020.

The submitted documentation indicates that Dr. Mitchell was ordered to address maximum medical improvement, impairment rating, and extent of injury. When multiple impairment ratings are required as a component of a designated doctor examination, the designated doctor shall be reimbursed $50 for each additional impairment rating calculation.[1]

Documentation supports that the designated doctor found that the injured employee was not at maximum medical improvement, so no impairment calculations were provided. Therefore, a charge for additional impairment calculations was not supported. The DWC does not recommend additional reimbursement for this charge.

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

Signature	Medical Fee Dispute Resolution Officer	January 8, 2021 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 §134.250(4)(B)