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**
RUSHING, DEAN HOLDEN

**Respondent Name**
HUNT REGIONAL HEALTHCARE

**MFDR Tracking Number**
M4-21-0159-01

**Carrier's Austin Representative**
Box Number 43

**MFDR Date Received**
October 1, 2020

## *REQUESTOR'S POSITION SUMMARY*

" 99456 WP W5 MMI = $350.00
IR – SHOULDER = $300.00
IR – BACK = $150.00
TTL = $800.00
PLEASE SEND AN ADDITIONAL $100.00"

**Amount in Dispute:** $100.00

## *RESPONDENT'S POSITION SUMMARY*

The Austin carrier representative for Hunt Regional Healthcare is Joseph Ivy Co. The representative was notified of this medical fee dispute on October 6, 2020. 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.

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| June 18, 2020 | Designated Doctor Examination (99456-W5-WP) | $100.00 | $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.

[1] 28 TAC §133.307(d)(1)

2. Texas Labor Code §408.0041 sets out the requirements for designated doctor examinations.

**Issues**

Is Dean Rushing, D.C. entitled to additional reimbursement for the examination in question?

**Findings**

Dr. Rushing is seeking additional reimbursement for an examination performed on June 18, 2020. Available information indicates that the designated doctor examination in question was canceled by the DWC on June 11, 2020, with notice sent to all parties.

The DWC concludes that no additional reimbursement can be recommended for this examination.

**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**

| | | |
|---|---|---|
| | | January 8, 2021 |
| 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**.