



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

MITCHELL, JACK PAUL JR

Respondent Name

EL PASO COUNTY COMMUNITY COLLEGE

MFDR Tracking Number

M4-21-0321-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

October 26, 2020

REQUESTOR'S POSITION SUMMARY

"Documentation submitted with the complete medical bill documents a designated doctor examination as ordered by the TDI/DWC, for the purpose of establishing Maximum Medical Improvement and providing an Impairment Rating for two separate body areas."

Amount in Dispute: \$150.00

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
July 23, 2020	Designated Doctor Examination (99456-W5-WP)	\$150.00	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 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 outlined in 134.204(j) for attainment of maximum medical improvement. An additional allowance is payable if a determination of the impairment caused by the compensable injury was also
 - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

- P12 – Workers’ compensation jurisdictional fee schedule adjustment.

Issues

1. Did El Paso Community College respond to the medical fee dispute?
2. Is Jack P. Mitchell, D.C. entitled to additional reimbursement for the service in question?

Findings

1. The Austin carrier representative for El Paso Community College is Downs Stanford PC. The representative was notified of this medical fee dispute on November 3, 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.

2. Dr. Mitchell is seeking additional \$150.00 reimbursement for a designated doctor examination performed on July 23, 2020. Dr. Mitchell argued that he was not paid for the impairment rating determined in the examination. No evidence was provided to support that an impairment rating was performed for this examination. The DWC cannot recommend additional reimbursement.

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 14, 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 §133.307(d)(1)