



Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name

Mitchell, Jack Paul Jr

Respondent Name

City of Fort Worth

MFDR Tracking Number

M4-22-0052-01

Carrier's Austin Representative

Box Number 04

DWC Date Received

September 10, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
May 20, 2021	99456 WP, W5	\$500.00	\$500.00
Total		\$500.00	\$500.00

Requestor's Position

...This provider should be reimbursed for first determining MMI for \$350.00, then Secondly for a DRE exam to spine of \$150, for total of \$500. Documentation submitted with the complete medical bill documents a designated doctor examination as ordered by the DWC, for the purpose of establishing Maximum Medical Improvement and providing an Impairment Rating.
 ...The insurance carrier does not have a valid reason for reducing this claim as billed.

Amount in Dispute: \$500.00

Respondent's Position

The Austin carrier representative for City of Fort Worth is Law Office of Ricky D Green. The representative was notified of this medical fee dispute on September 21, 2021.

Per 28 Texas Administrative Code §133.307(d)(1), 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.

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

Findings and Decision

Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. 28 TAC §134.240 sets out requirements of billing and reimbursement of designated doctor exams.

Denial Reasons

Neither party submitted an explanation of benefits with reasons for the reduction or denial of payment for the disputed services.

Issues

1. Did the insurance carrier support adjudication of the service in dispute?
2. Was the medical submitted per applicable DWC rules?
3. What rule(s) apply to reimbursement of disputed service?

Findings

1. The requestor is seeking reimbursement of impairment rating and maximum medical improvement (MMI). The insurance carrier did not submit sufficient documentation to support adjudication of the services in dispute. The services will be reviewed per applicable fee guidelines.
2. DWC Rule 28 TAC §§134.250 (4)(A) and 134.240 (1)(A) require the doctor to bill with CPT code 99456 and modifier "W5."

When the examining doctor also performs the testing for impairment rating of musculoskeletal body areas, 28 TAC §134.250 (4)(C)(iii) requires the examining doctor to add modifier "WP."

Review of the submitted medical bill finds that Dr. Jack P Mitchell performed impairment

rating evaluation of lumbar and cervical spine with range of motion testing.

DWC Rule TAC §134.250 (4)(C)(i) states in pertinent part, musculoskeletal body areas are defined as (1) spine and pelvis.

3. DWC Rule 28 TAC §134.250 (4)(C) defines the fee states the reimbursement of the MMI is \$350.00. The impairment rating is reimbursed at \$150.00.

Review of the submitted documentation finds the total MAR for the MMI and determination of impairment rating is \$500.00. This amount is recommended.

Conclusion

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

DWC finds the requester has established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that City of Fort Worth must remit to Dr. Jack Mitchell \$500.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 17, 2021

Date

Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico CompConnection@tdi.texas.gov.