



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Elite Healthcare Ft Worth

**Respondent Name**

Protective Insurance Co

**MFDR Tracking Number**

M4-22-1619-01

**Carrier's Austin Representative**

Box Number 17

**DWC Date Received**

April 1, 2022

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 30, 2021	99361	\$113.00	\$0.00
<b>Total</b>		\$113.00	\$0.00

### Requestor's Position

"...please see attached documentation showing billing and reimbursement are accordingly to Rule 134.204. Documented changes have been marked for your reference."

**Amount in Dispute:** \$113.00

### Respondent's Position

The Austin carrier representative for Protective Insurance Co is Downs Stanford PC. The representative was notified of this medical fee dispute on April 5, 2022.

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 §134.220 sets out the requirements of case management.

### Denial Reasons

- 234 – This procedure is not paid separately
- W1 – Case management services
- 193 – Original payment decision maintained

### Issues

1. Did the requestor support their position regarding change of condition?

### Findings

1. The requestor is seeking reimbursement of a team conference for date of service April 30, 2021. DWC Rule 134.220 (2) states, Team conferences and telephone call should be triggered by a documented change in the condition of the injured employee and performed for the purpose of coordination of medical treatment and/or return to work for the injured employee.

The requestor states in the position statement, "Documented changes have been marked for your reference." Review of the submitted "Team Conference" dated April 30, 2021, does not indicate the change in condition that prompted the team conference. The respondent's position statement is not supported. No payment 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 not established that additional reimbursement is due.

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

### Authorized Signature

_____	Peggy Miller	June 21, 2022
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 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](http://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](mailto: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](mailto:CompConnection@tdi.texas.gov).