



# 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 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

### MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

#### GENERAL INFORMATION

**Requestor Name**

J. Thomas Dilger, Jr., MD

**Respondent Name**

Kiewit Corporation

**MFDR Tracking Number**

M4-13-2235-01

**Carrier's Austin Representative**

Box Number 19

**MFDR Date Received**

May 3, 2013

#### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "This is a Designated Doctor Exam performed on 12/14/12. Despite multiple attempts to collect on this claim, the insurance carrier is attempting theft of services rendered. The DDE & claim were faxed to the carrier on 12/16/12. Therefore MDR is filed via certified mail with receipt."

**Amount in Dispute:** \$850.00

#### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Carrier will review the disputed bill for proper payment."

**Response Submitted by:** Flahive, Ogden & Latson, Post Office Drawer 201329, Austin, TX 78720

#### SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 14, 2012	Designated Doctor Examination	\$850.00	\$0

#### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- The services in dispute were reduced/denied by the respondent with the following reason codes:  
No explanation of benefits was provided with this dispute.

**Issues**

- Is the requestor entitled to reimbursement?

**Findings**

- The requestor is seeking \$850.00 for reimbursement of a designated doctor examination to determine maximum medical improvement, impairment rating, and return to work. Review of the submitted documentation finds that the insurance carrier reimbursed the provider \$906.05 on 12/9/14. Therefore, the

Division finds that the requestor has been reimbursed in full, with all applicable interest.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

**ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

	Laurie Garnes	March 27, 2015
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 28 Texas Administrative Code §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 Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **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.**