TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Nader Awwad, D.C.

Respondent Name
ACE American Insurance Company

MFDR Tracking Number
M4-16-0832-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
November 25, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Based on the examination type requested and performed, the fact that the carrier had already approved payment (evidenced by the EOB stating the payment was made) and the lack of receipt of funds for the state mandated Designated Doctor examination, the claim should be paid in full via check."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent received a medical bill from Requestor for a designated doctor's examination. The medical bill was audited on 2/11/15 allowing reimbursement of $500.00. On 2/12/15, $500.00 was sent to Requestor via ACH electronic payment."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 24, 2014	Designated Doctor Examination	$500.00	$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.

Background

1. 28 Texas Administrative Code §133.305 sets out the procedures for resolving medical disputes.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

3. Submitted documentation did not include denial or reduction of billed services by the insurance carrier.

Issues

Does a medical fee dispute exist for the services in question?

Findings

The requestor is seeking medical fee dispute resolution for a designated doctor examination, procedure code 99456-W8-RE. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as:

> A dispute that involves an amount of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury… The following types of disputes can be a medical fee dispute:
> (A) a health care provider, or a qualified pharmacy processing agent as described in Labor Code §413.0111, dispute of an insurance carrier **reduction or denial** [emphasis added] of a medical bill;
> (B) an injured employee dispute of reduction or denial of a refund request for health care charges paid by the injured employee; and
> (C) a health care provider dispute regarding the results of a division or insurance carrier audit or review which requires the health care provider to refund an amount for health care services previously paid by the insurance carrier.

Review of the submitted documentation does not support that the insurance carrier reduced or denied a medical bill for the services in question. The explanation of benefits indicates a reimbursement of $500.00, the full amount sought by the requestor. Therefore, no medical fee dispute exists for the services in question.

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	February 18, 2016
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, 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 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 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.