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
Jason Eaves, D.C.

Respondent Name
Great Midwest Insurance Company

MFDR Tracking Number
M4-19-3201-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
February 19, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The services were billed correctly via fax on 3/8/2018 to (515) 221-7036 which is listed on the DWC032 as the bill review agent fax number … However, no EOB was received … I sent a request for reconsideration on 8/15/2018 to (515) 221-7036 which is listed on the DWC032 as the bill review agent fax number … No EOB was received."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

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
February 16, 2018	Designated Doctor Examination	$650.00	$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 §133.307 sets out the procedures for resolving medical fee disputes.
2. No explanations of benefits were submitted for the date of service in dispute.

Issues

1. Did Great Midwest Insurance Company respond to the medical fee dispute?
2. Is Dr. Eaves entitled to reimbursement for the dispute in question?

Findings

1. The Austin carrier representative for Great Midwest Insurance Company is Flahive Ogden & Latson. Flahive Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on February 27, 2019. Rule §133.307(d)(1) states that 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 carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. Dr. Eaves is seeking reimbursement for a designated doctor examination performed on February 16, 2018.

   Requests for medical fee dispute resolution (MFDR) may not be filed later than one year after the date of service.[1] Exceptions to this filing deadline are limited to issues of compensability, extent of injury, or liability; medical necessity; or a request for refund.[2]

   The request for MFDR was received on February 19, 2019. This is more than one year after the date of service. No evidence was presented that this dispute meets one of the exceptions set forth. For this reason, Dr. Eaves has waived the right to MFDR.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	August 16, 2019
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 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 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. **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 Texas Administrative Code §133.307(c)(1)(A)
[2] 28 Texas Administrative Code §133.307(c)(1)(B)