TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
John D. Kirkwood, D.O.

Respondent Name
Old Republic Insurance Company

MFDR Tracking Number
M4-19-3245-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
February 25, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance carrier has failed to submit payment for the *Medical Fee Guidelines* allowable for a State issued Designated Doctors Evaluation."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Designated doctor check was issued on 11-19-18 in the amount of $500.00 check#0150392351…"

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 8, 2018	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

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

Issue

Is the requestor entitled to additional reimbursement?

Findings

Dr. Kirkwood is seeking reimbursement of $500.00 for a designated doctor examination performed on November 8, 2018. The greater weight of evidence presented to the DWC supports that the insurance carrier reimbursed $500.00 for the examination in question on November 20, 2018. No additional reimbursement is recommended.

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	April 18, 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.