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
Karrn Bales, D.O.

Respondent Name
Truck Insurance Exchange

MFDR Tracking Number
M4-19-3415-01

Carrier's Austin Representative
Box Number 14

MFDR Date Received
March 12, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Today, March 5, 2019, JKB Medical Exams has not received payment nor the EOB for the bill submitted for the date of service 10/16/18."

Amount in Dispute: $500.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel has no record of receipt of a CMS-1500 billing form for date of service 10/16/18, CPT code 99456 (WP, RE, W6) in the, amount of $500.00."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 16, 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

1. 28 Texas Administrative Code §133.20 sets out the procedures for submission of a medical bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. The submitted documentation does not include an explanation of benefits for the service in question.

Issues

Is the requestor entitled to reimbursement for the service in dispute?

Findings

Dr. Bales is seeking reimbursement for a designated doctor examination performed on October 16, 2018. In its position statement, CorVel, on behalf of Truck Insurance Exchange, stated that it did not receive a medical bill for the examination date in dispute.

The health care provider is required to submit a medical bill within 95 days from the date of service.[1] Submitted evidence does not support that a medical bill for the examination considered in this dispute was submitted to the insurance carrier.

The DWC concludes that Dr. Bales is not entitled to reimbursement for the disputed service.

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	May 15, 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 §133.20(b)