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
Jarrett Armstrong, D.C.

Respondent Name
Vanliner Insurance Company

MFDR Tracking Number
M4-19-4859-01

Carrier's Austin Representative
Box Number 6

MFDR Date Received
July 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED"

Amount in Dispute: $890.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On reconsideration, Vanliner has elected to pay for the services in dispute."

Response Submitted by: Stone Loughlin Swanson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 31, 2019	Designated Doctor Examination	$890.00	$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 (DWC). 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

Is Dr. Armstrong entitled to additional reimbursement?

Findings

Dr. Armstrong is seeking reimbursement of $890.00 for a designated doctor examination performed on January 31, 2019.

Per explanation of benefits dated March 11, 2019, the insurance carrier made a partial payment of $875.00. Per explanation of benefits dated July 24, 2019, the insurance carrier made an additional payment of $15.00. Together, these payments are a total reimbursement of $890.00, the full amount sought by Dr. Armstrong.

These payments are further supported by a payment history submitted by the insurance carrier dated August 2, 2019. This payment history indicates the reimbursements recommended by the insurance carrier were paid via check numbers 4848278 and 4890764.

The DWC concludes that Dr. Armstrong has been reimbursed in full for the examination in question. No further reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC 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 DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

________________________	Laurie Garnes	September 27, 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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.