



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

Daniel O. Thompson, III, M.D.

Respondent Name

XL Insurance America, Inc.

MFDR Tracking Number

M4-19-4969-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

July 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Sedgwick Insurance Company has refused to pay the full amount owed me for a designated doctor issue (MMI/IR) that I performed on instruction from the Division."

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Attached please find the amended EOR allowing an additional \$150.00 as requested by the provider."

Response Submitted by: Coventry

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 27, 2018	Designated Doctor Examination	\$150.00	\$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).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed examinations citing fee guidelines.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Dr. Thompson is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating.

Documentation submitted by the insurance carrier indicates that it reimbursed the requested amount on or about September 4, 2019, via check number 106197479. Therefore, according the evidence presented, the total amount paid to Dr. Thompson is \$1,150.00, which is the total billed.

No additional 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	October 23, 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.