



# 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**

Geneva Medical Management, Inc.

**Respondent Name**

ACE American Insurance Company

**MFDR Tracking Number**

M4-20-0062-01

**Carrier's Austin Representative**

Box Number 15

**MFDR Date Received**

September 10, 2019

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Reimbursement for one of these exams is \$500 ... We seek full reimbursement for the outstanding balance of \$250.00 along with interest accrued according to Rule 134.803 Calculating Interest for Late Payments on Medical Bills."

**Amount in Dispute:** \$250.00

### 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
March 26, 2019	Designated Doctor Examination	\$250.00	\$250.00

### 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. 28 Texas Administrative Code §134.235 sets out the fee guidelines for examinations to determine the extent of the compensable injury.
3. The insurance carrier reduced payment for the disputed examination citing fee guidelines.

**Issues**

1. Did ACE American Insurance Company respond to the medical fee dispute?
2. Is Geneva Medical Management, Inc. entitled to additional reimbursement for the examination in question?

**Findings**

1. The Austin carrier representative for ACE American Insurance Company is Downs Stanford, PC. The representative received the copy of this medical fee dispute on September 17, 2019. 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.<sup>1</sup>

As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. Geneva Medical Management, Inc. is seeking additional reimbursement for a designated doctor examination to determine the extent of the compensability performed by Dr. Paul Patrick on March 26, 2019.

The submitted documentation supports that Dr. Patrick performed the examination to determine the extent of injury as ordered by the DWC. Per 28 TAC §134.235, the maximum allowable reimbursement for this examination is \$500.00. The insurance carrier paid \$250.00. An additional \$250.00 is recommended.

**Conclusion**

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$250.00.

***ORDER***

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor \$250.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

**Authorized Signature**

	Laurie Garnes	November 14, 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.**

<sup>1</sup> 28 TAC §133.307(d)(1)