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
ALIANELL, SAMUEL J

Respondent Name
PROTECTIVE INSURANCE CO

MFDR Tracking Number
M4-20-1027-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
December 23, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The charges herein were filed with the Carrier and a payment was issued, however this health care provider never received the payment. The carrier advised the check had been tendered and provided us a copy of the check, front and back. The endorsement on back of the check clearly indicated that the check had been cashed by someone other than this health care provider. We attempted to locate the entity that cashed this check with no success."

Amount in Dispute: $119.01

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Protective maintains that the requestor Samuell Alienell, MD PA is not entitled to additional reimbursement from Protective for date of service 4/24/19 in the amount of $119.01 as payment has been tendered and the invoice paid."

Response Submitted by: Protective Insurance Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 24, 2019	Evaluation and Management Examination (99213)	$119.01	$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 §133.305 defines the authority of the DWC to adjudicate medical disputes. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

Issues

Is the requestor entitled to additional reimbursement?

Findings

Samuel Alienell, M.D. is seeking reimbursement for an evaluation and management examination performed on April 24, 2019.

The DWC has the authority to review medical fee disputes that involve "an **amount** of payment for non-network health care rendered to an injured employee that has been determined to be medically necessary and appropriate for treatment of that injured employee's compensable injury [emphasis added]."[1]

A medical fee dispute from a health care provider is a "dispute of an insurance carrier **reduction or denial** of a medical bill."[2]

In review of the records submitted, the DWC finds that neither party asserts that the insurance carrier denied the bill in question or disputed the amount of the reduction of payment. For this reason, the DWC finds that it does not have the authority to adjudicate the issue as presented.

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

Signature	Medical Fee Dispute Resolution Officer	Date
		May 7, 2020

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.

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[1] 28 TAC §133.305 (a)(4)

[2] 28 TAC §133.305 (a)(4)(A)