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
EAVES, JASON LEVON

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number
M4-20-1566-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
February 20, 2020

REQUESTOR'S POSITION SUMMARY

"A designated doctor MMI examination was performed on 2/11/2019 at t6he order of the Texas Department of Insurance for disability and return to work. $500.00 was billed for 99456 with the modifiers W7 and RE which represents the disability portion of the examination. $250.00 was billed for 99456 with the modifiers W8 and RE which represents the return to work portion of the examination … This bill is correct, reduction is not valid, and this bill should be paid in full."

Amount in Dispute: $471.23

RESPONDENT'S POSITION SUMMARY

"Please see the attached EOB which shows payment was issued in the amount of $471.23 via electronic funds transfer on 3/20/2020."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 11, 2019	Designated Doctor Examination (99456-W7-RE and 99456-W8-RE)	$471.23	$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 Jason L. Eaves, D.C. entitled to additional reimbursement?

Findings

Dr. Eaves is seeking an additional $471.23 for a designated doctor examination performed on February 11, 2019. Per explanation of benefits dated February 28, 2020, the insurance carrier reimbursed this amount in full. 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

		July 23, 2020
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.