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
COX, ANGELA B

Respondent Name
TRI-STATE INSURANCE COMPANY OF MINNESOTA

MFDR Tracking Number
M4-21-0796-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 19, 2021

REQUESTOR'S POSITION SUMMARY

" MMI = $350.00
IR – W/ROM = $300.00
TTL = $650.00"

Amount in Dispute: $300.00

RESPONDENT'S POSITION SUMMARY

"It appears that following the carrier's receipt of the DWC-60, the carrier reprocessed the provider's bill and recommended additional reimbursement of $800.00. We believe that the amount has been paid to the provider such that the provider has been paid a total of $1,150 when the provider was entitled to only $650."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 2, 2020	Designated Doctor Examination (99456-W5-WP)	$300.00	$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 Angela Cox, D.C. entitled to additional reimbursement?

Findings

Dr. Cox is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating. Per explanation of benefits dated January 28, 2021, submitted by the insurance carrier, the requested amount has been paid 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

		March 5, 2021
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.