Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SHANNON CLINIC

Respondent Name
OLD REPUBLIC GENERAL INSURANCE

MFDR Tracking Number
M4-12-1164-01

Carrier's Austin Representative Box
Box Number 44

MFDR Date Received
December 14, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier has denied as should be included in global surgical package. Surgery was performed by different doctor."

Amount in Dispute: $122.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Confirmed the bill was reviewed and processed correct per the TX state guidelines."

Response Submitted by: Gallagher Bassett Services, LLC.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 3, 2011	99214	$122.00	$0

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. No Explanation of Benefits provided

Issues

1. Did the requestor file in the form and manner prescribed by the division?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307 states requests for medical dispute shall include the following: "(c)… Requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. .. (2)Provider Request. The provider shall complete the required sections of the request in the form

and manner prescribed by the Division. The provider shall file the request with the MDR Section by any mail service or personal delivery. The request shall include: (A)a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills); (B)a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB…" Review of the documentation submitted by the requestor finds that the requestor did not include copies of the EOB's received The division finds that the requestor did not file in the form and manner prescribed by the division.

2. For the reasons stated above, the division finds that the requestor is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 11, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.