



# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**

John P. Hodges, D.C.

**Respondent Name**

Arch Indemnity Insurance Co.

**MFDR Tracking Number**

M4-24-2757-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

August 14, 2024

## Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
July 24, 2024	Designated Doctor Examination 99456-NM	\$449.00	\$0.00

## Requestor's Position

Initial position statement: "The carrier remitted \$449.00 on check number: 0200259020; however, once I deposited it, placed a 'STOP PAYMENT' on the check without any explanation or prenotification.

"By placing a 'STOP PAYMENT' on my remittance without warning or prenotification, Arch Indemnity Insurance Company/Gallagher Bassett Services Inc. and Jerri Portugal, adjuster, caused my bank to debit my account for the \$449.00 and an additional charge of \$20.00 for a returned check ...

"I am requesting payment of the owed \$449.00 **AND** the \$20.00 I was charged for the 'STOP PAYMENT', any applicable interest for the provided Designated Doctor Examination that was requested by the insurance carrier and not paid within the allotted 45 days."

Supplemental position statement: "Please continue with MDR... the carrier still has not paid the \$20.00 stop check fee that they caused by putting a stop payment on the check they issued initially on this claim that I deposited. Moreover, they put the stop payment on the initial check

without warning or contacting me first. Furthermore, interest is owed for late payment as well.”

**Amount in Dispute:** \$449.00

### **Respondent's Position**

“Our bill audit company has determined no further payment is due ... Rationale: This was paid on 8/26/2024.”

**Response Submitted by:** Gallagher Bassett

### **Findings and Decision**

#### Authority

This medical fee dispute is decided according to [Texas Labor Code \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers’ Compensation (DWC).

#### Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.240](#) sets out the fee guidelines for designated doctor examinations.

#### Denial Reasons

Neither party submitted an explanation of benefits with reasons for the payment, reduction, or denial of payment for the disputed services.

#### Issues

1. Is John P. Hodges, D.C. entitled to additional reimbursement?

#### Findings

1. Dr. Hodges submitted a request for medical fee dispute resolution seeking \$449.00 for a designated doctor examination performed on July 24, 2024, to determine maximum medical improvement.

Per 28 TAC §134.240 (d)(3), reimbursement for an examination by a designated doctor to determine maximum medical improvement is \$449.00. In its position statement, the insurance carrier stated that this amount was paid on August 26, 2024.

While no explanation of benefits was received, the requestor indicated in a supplemental statement that it received this payment but is now seeking additional reimbursement. Because the parties agree that payment for the services in question were paid in accordance with 28 TAC §134.240, no additional reimbursement can be recommended in this dispute.

## Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requestor has not established that additional reimbursement is due.

## **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to \$0.00 reimbursement for the disputed services.

## **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

January 23, 2025  
\_\_\_\_\_  
Date

## **Your Right to Appeal**

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option three or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in [28 TAC §141.1 \(d\)](#).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción tres o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).