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 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

AMENDED MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Robert Jaehne, D.C.

Respondent Name
Great Midwest Insurance Company

MFDR Tracking Number
M4-18-4840

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 9, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUIRED TO PAY DESIGNATED DOCTOR EXAMS"

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a position statement from the respondent. Accordingly, this decision is based on the information available at the time of adjudication.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 13, 2018	Designated Doctor Examination	$350.00	$350.00

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.

Background

1. 28 Texas Administrative Code §133.240 sets out the procedures for payment or denial of a medical bill.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.240 sets out the procedures for billing a designated doctor examination.
4. 28 Texas Administrative Code §134.250 sets out the fee guidelines for maximum medical improvement and impairment rating.
5. The submitted documentation does not include explanations of benefits.

Issues

1. Did Great Midwest Insurance Company respond to the medical fee dispute?
2. Is Robert Jaehne, D.C. entitled to reimbursement for the service in question?

Findings

This **amended** Findings and Decision supersedes all previous decisions rendered in this medical payment dispute involving the above requestor and respondent.

1. The insurance carrier's Austin representative acknowledged receipt of the copy of this medical fee dispute on Flahive, Ogden & Latson. The insurance carrier's response is considered timely if it is submitted within 14 calendar days after the date the insurance carrier's representative received the copy of the dispute. If a response is not received within 14 calendar days of the dispute notification, then the decision may be based on the available information.[1]

   No response has been received on behalf of Great Midwest Insurance Company to date. For that reason, the decision will be based on the information available.

2. Dr. Jaehne is seeking reimbursement for a designated doctor examination to determine if the injured employee had reached maximum medical improvement (MMI). The insurance carrier failed to provide evidence that it took final action by paying, reducing, or denying the service in question.[2] Therefore, Dr. Jaehne is entitled to reimbursement for the service in question, in accordance with relevant statutes and rules.

   Dr. Jaehne billed the examination in question with code 99456-W5-NM representing a designated doctor examination to determine MMI with a finding that the injured employee had not reached MMI.[3] The Texas Department of Insurance, Division of Workers' Compensation finds that Dr. Jaehne is entitled to reimbursement of $350.00 for the service in question.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $350.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $350.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	October 30, 2018
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §133.307(d)(1)
[2] 28 Texas Administrative Code §133.240(a)
[3] 28 Texas Administrative Code §134.240(1)(B); 28 Texas Administrative Codes §134.250(2)(A) and (3)(C)

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 division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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.