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
Anthony Owusu, M.D.

Respondent Name
New Hampshire Insurance Company

MFDR Tracking Number
M4-19-2251-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 18, 2018

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our office has not received and explanation of benefits for our claim submission."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Payment has been disputed as the claimant already requested an alternate impairment rating which was completed."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 28, 2018	Examination to Determine Maximum Medical Improvement and Impairment Rating	$650.00	$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).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. Texas Labor Code §408.0041 sets out the conditions relating to a designated doctor examination.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - D48 – Payment denied/reduced for absence of or exceeded referral
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

Are the insurance carrier's reasons for denial or reduction of payment supported?

Findings

Anthony Owusu, M.D., a doctor selected by the treating doctor acting in place of the treating doctor, is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating performed on July 18, 2018. The insurance carrier denied the examination for absence of or exceeded referral.

Documentation available to the division finds that the first evaluation of impairment rating for this injured employee's compensable injury was provided by Frances X. Burch, M.D., a doctor selected by the treating doctor acting in place of the treating doctor.

An insurance carrier is required to pay for an examination to determine maximum medical improvement and impairment rating performed at the request of the injured employee after a designated doctor examination if:

- the designated doctor examination is the employee's first evaluation of maximum medical improvement and impairment rating, and
- the employee is not satisfied with the designated doctor's opinion.[1]

The division finds that the first evaluation of maximum medical improvement and impairment rating was not performed by a designated doctor. Therefore, no reimbursement is recommended for the service in question.

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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	March 4, 2019
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 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.

[1] Texas Labor Code §408.0041(f-2) and (h)(1)