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
Melburn K. Huebner, M.D.

Respondent Name
Old Republic Insurance Company

MFDR Tracking Number
M4-19-3559-01

Carrier's Austin Representative
Box Number 44

MFDR Date Received
March 25, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The total MAR for an MMI/IR examination shall be equal to the MMI evaluation reimbursement ($350.00) plus the reimbursement for the body area (s), see Section 4 C, evaluated for the assignment of an IR, the first body area is $300.00."

Amount in Dispute: $300.00

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 5, 2019	Examination to Determine Maximum Medical Improvement and Impairment Rating	$300.00	$300.00

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 §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Exact duplicate claim/service.
   - 247 – A payment or denial has already been recommended for this service.
   - W3 – Additional payment made on appeal/reconsideration
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

- 1002 – Due to an error in processing the original bill, we are recommending further payment be made for the above noted procedure.

Issues

1. Did Old Republic Insurance Company respond to the medical fee dispute?
2. Is Dr. Huebner entitled to additional reimbursement for the services in question?

Findings

1. The Austin carrier representative for Old Republic Insurance Company is White Espey, PLLC. White Espey, PLLC acknowledged receipt of the copy of this medical fee dispute on April 3, 2019. Rule §133.307(d)(1) states that if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

   As of today, no response has been received from the carrier or its representative. We therefore base this decision on the information available as authorized under §133.307(d)(1).

2. Dr. Huebner is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating. Old Republic Insurance Company reduced the reimbursement citing the medical fee guidelines.

   The submitted documentation supports that Dr. Huebner performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.[1]

   The submitted documentation supports that Dr. Huebner provided an impairment rating for a musculoskeletal body area, performing a full physical evaluation with range of motion of the left upper extremity. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[2]

   The total allowable reimbursement for the services in question is $650.00. The insurance carrier reimbursed $350.00. An additional reimbursement of $300.00 is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $300.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	August 14, 2019
Signature	Medical Fee Dispute Resolution Officer	Date

[1] 28 Texas Administrative Code §134.250(3)(C)
[2] 28 Texas Administrative Codes §§134.250(4)(C)(ii)(II)(-a-)

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.