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
American Zurich Insurance Company

MFDR Tracking Number
M4-19-3591-01

Carrier's Austin Representative
Box Number 19

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: "The carrier is going to be reprocessing the provider's bill based upon the impairment rating portion of the exam."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 24, 2018	Examination to Determine Maximum Medical Improvement	$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 (DWC).

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:
    - P12
    - W3

Issues

Is Dr. Huebner entitled to additional reimbursement?

Findings

In the dispute before the DWC, Dr. Huebner is seeking reimbursement for an examination to determine the maximum medical improvement and impairment rating. American Zurich Insurance Company reduced the reimbursement for this examination citing the fee guidelines.

Reimbursement is $350.00 for an examination to determine maximum medical improvement.[1] 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.

The submitted documentation supports that Dr. Huebner provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the right elbow. The MAR $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 service in dispute is $650.00. The insurance carrier reimbursed $350.00. An additional $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	May 15, 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.

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[1] 28 Texas Administrative Code §134.250(3)(C)

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