



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

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Russell Juno, M.D.

Respondent Name

United Airlines, Inc.

MFDR Tracking Number

M4-19-4405-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

June 3, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "SERVICE BILLED WAS AT THE REQUEST OF THE TREATING DOCTOR. OUR OFFICE HAS NOT RECEIVED AN EOB IN RESPONSE TO OUR REQUEST FOR RECONSIDERATION SUBMITTED."

Amount in Dispute: \$650.00

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
October 2, 2018	Examination to Determine Maximum Medical Improvement and Impairment Rating	\$650.00	\$650.00

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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 245 – Denied per customer request

Issues

1. Did United Airlines, Inc. respond to the medical fee dispute?
2. Is the insurance carrier’s denial of payment for the services in question supported?
3. Is Dr. Juno entitled to reimbursement for the disputed examination?

Findings

1. The Austin carrier representative for United Airlines, Inc. is Flahive Ogden & Latson. Flahive Ogden & Latson acknowledged receipt of the copy of this medical fee dispute on June 11, 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 insurance carrier or its representative. We therefore base this decision on the information available as authorized under 28 TAC §133.307(d)(1).

2. Dr. Juno is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating. The insurance carrier provided no defense for its denial based on “customer request.” The DWC finds that the denial is not supported.
3. Because the insurance carrier failed to support its denial of payment, Dr. Juno is entitled to reimbursement for the services in question.

The submitted documentation supports that Dr. Juno 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. Juno provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the spine. Reimbursement is \$300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.²

The total allowance for the services in question is \$650.00. This amount 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 \$650.00.

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 \$650.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	October 11, 2019 Date
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¹ 28 TAC §134.250(3)(C)

² 28 TAC §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 DWC within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the DWC 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.