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
OWUSU, ANTHONY JR

Respondent Name
ARCH INDEMNITY INSURANCE CO

MFDR Tracking Number
M4-21-0368-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 13, 2020

REQUESTOR'S POSITION SUMMARY

"POST DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED"

Amount in Dispute: $1,150.00

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
November 22, 2019	Examination to Determine Maximum Medical Improvement and Impairment Rating (99456-WP)	$1,100.00	$1,100.00
November 22, 2019	Specialist Report (99456-SP)	$50.00	$50.00
	Total	$1,150.00	$1,150.00

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:
   - Charges have been reduced or denied per bill review rules.

Issues

1. Did Arch Indemnity Insurance Company respond to the medical fee dispute?
2. Is Anthony Owusu, M.D. entitled to reimbursement for the services in question?

Findings

1. The Austin carrier representative for Arch Indemnity Insurance Company is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on November 10, 2020. 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.[1]

   As of today, no response has been received from the insurance carrier or its representative. We will base this decision on the information available.

2. Dr. Owusu is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating.

   The submitted documentation supports that Dr. Owusu performed an evaluation of maximum medical improvement. The maximum allowable reimbursement (MAR) for this examination is $350.00.[2]

   Review of the submitted documentation finds that Dr. Owusu performed impairment rating evaluations of the spine, bilateral upper extremities, bilateral lower extremities, and a head injury with range of motion testing of the musculoskeletal areas. The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[3] The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each.[4] The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.[5] The total MAR for the determination of impairment rating is $750.00.

   Dr. Owusu referred the injured employee to a specialist to provide a report to aid in determining the impairment rating for the head injury. The use of this report is noted in the narrative. Therefore, the correct MAR for this service is $50.00.[6]

   The total allowable reimbursement for the disputed services is $1,150.00. 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 $1,150.00.

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 $1,150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 29, 2021 Date

[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §134.250(3)(C)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[4] 28 TAC §134.250(4)(C)(ii)(II)(-b-)
[5] 28 TAC §134.250(4)(D)(v)
[6] 28 TAC §134.250 (4)(D)(iii)

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.