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
MEDICAL EQUATION

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-21-0720-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
December 28, 2020

REQUESTOR'S POSITION SUMMARY

"Dr. Obermiller addressed 1 body area using the DRE method. The carrier has denied partial payment on examination services provided, which all are per their request."

Amount in Dispute: $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
August 27, 2020	Required Medical Examination to Determine Maximum Medical Improvement and Impairment Rating (99456-WP)	$150.00	$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:
   - P12 – Workers' compensation fee schedule adjustment.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 247 – A payment or denial has already been recommended for this service.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 5283 – Additional allowance is not recommended as this bill was reviewed in accordance with state guidelines, usual and customary policies, provider's contract, or car

Issues

1. Did New Hampshire Insurance Co respond to the medical fee dispute?
2. Is Medical Equation entitled to additional reimbursement for the examination in question?

Findings

1. The Austin carrier representative for New Hampshire Insurance Co is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on January 5, 2021. 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. Medical Equation is seeking an additional $150.00 for an examination to determine maximum medical improvement and impairment rating.

   The submitted documentation supports that John P. Obermiller, M.D. 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. Obermiller performed impairment rating evaluations of the spine, shoulder, and knee with range of motion testing; and post-concussion syndrome. 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 a musculoskeletal body area determined using the DRE method is $150.00.[4] The MAR for the evaluation of subsequent musculoskeletal body areas is $150.00 each.[5] The MAR for the assignment of impairment rating for non-musculoskeletal body areas is $150.00 each.[6] The total MAR for the determination of impairment rating is $750.00.

   The total allowable reimbursement for the examination in question is $1,100.00. The insurance carrier paid $800.00. Medical Equation is seeking $150.00. This amount is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. 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 $150.00.

[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)(I)
[5] 28 TAC §134.250(4)(C)(ii)(II)(-b-)
[6] 28 TAC §134.250(4)(D)(v)

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

Authorized Signature

		March 18, 2021
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 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.