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
GREAT AMERICAN ALLIANCE INSURANCE CO

MFDR Tracking Number
M4-21-1320-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
March 31, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the DWC022, Dr. Obermiller was asked to address Maximum Medical Improvement and Impairment Rating. The carrier has not responded in payment or final communication for full payment on examination services provided, which are all per their request. We originally sent the invoice and all documentation email on 08/14/20."

Amount in Dispute: $800.00

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
July 28, 2020	Examination to Determine Maximum Medical Improvement and Impairment Rating (99456-WP)	$800.00	$800.00

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 submitted documentation does not included explanations of benefits.

Issues

1. Did the insurance carrier respond to the medical fee dispute?
2. Did the insurance carrier take final action on the bill for the service in question prior to the request for medical fee dispute resolution (MFDR)?
3. Is Medical Equation entitled to reimbursement for the services in question?

Findings

1. The Austin carrier representative for Great American Alliance Insurance Co is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on April 6, 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 reimbursement for a required medical examination to determine maximum medical improvement and impairment rating.

   Medical Equation argued that it had not received payment or an explanation of denial for medical bills submitted for the examination in question.

   The insurance carrier is required to take final action by paying, reducing, or denying the service in question not later than 45 days after receiving the medical bill. This deadline is not extended by a request for additional information.[2]

   The greater weight of evidence presented to the DWC supports that a complete bill for the services in question was received by the insurance carrier or its agent. No evidence was provided to support that the insurance carrier took final action on the bill for the service in question.

3. Because the insurance carrier failed to raise any defense for non-payment of the services in question, Medical Equation is entitled to reimbursement.

   The submitted documentation supports that John P. Obermiller, M.D. performed an evaluation of maximum medical improvement, as requested by the insurance carrier. The maximum allowable reimbursement (MAR) for this examination is $350.00.[3]

   Review of the submitted documentation finds that Dr. Obermiller performed impairment rating evaluations of the upper extremity with range of motion testing, and the skin. The MAR for the evaluation of a musculoskeletal body area performed with range of motion is $300.00.[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 $450.00.

   The total allowable reimbursement for the services in question is $800.00. This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered. For the reasons stated above, the Texas Department of Insurance, Division of Workers' Compensation (DWC) finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $800.00.

[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §133.240 (a)
[3] 28 TAC §134.250(3)(C)
[4] 28 TAC §134.250(4)(C)(ii)(II)(-a-)
[5] 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 $800.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		June 25, 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 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.