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
ERWIN, KARL DANIEL

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-21-1969-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 9, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The RME exam was requested by the New Hampshire Ins. Co and was approved and ordered by the TDI Division of WC … Our claim was originally denied for lack of support documentation on 09/04/2020. Though we have proof that of a successful fax transmission report to show all supporting documentation (44 pages) were sent to the adjuster Brenda Sneed on 08/21/2020; we went ahead and submitted documentation again on May 13, 2021 as a request for reconsideration … I spoke with a Melissa of Gallagher Bassett main office, she verified that bill review audited and allowed payment of $1350.00; however, she is not able to provide EOB and advised that I'd speak with the Adjuster Brenda Sneed."

Amount in Dispute: $1,400.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our bill audit company stands on their original review … The provider is not due any additional monies as the fee schedule was applied correctly."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 7, 2020	Required Medical Examination	$500.00	$500.00
		$350.00	$350.00
		$300.00	$300.00
		$150.00	$150.00
		$100.00	$0.00
	Total	$1,400.00	$1,300.00

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 §134.235 sets out the fee guidelines for examinations to determine extent of the compensable injury.
3. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
   - 5779 – Payment recommended is pending as the payer has requested supporting documentation to substantiate this service. Please re-submit with documentation for reimburs
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 296 – Service exceeds maximum reimbursement guidelines.

Issues

1. Is New Hampshire Insurance Company's denial of payment supported?
2. Is Karl D. Erwin, M.D. entitled to reimbursement for the examination in question?

Findings

1. Dr. Erwin is seeking reimbursement for a required medical examination performed on August 7, 2020. The insurance carrier denied payment based on lack of documentation.

   The greater weight of evidence provided to the DWC supports that the insurance carrier received documentation for the services billed. No evidence was provided to the contrary. The insurance carrier's denial for this reason is not supported.

2. Because the insurance carrier did not support its denial of payment, Dr. Erwin is entitled to reimbursement.

   The submitted documentation indicates that Dr. Erwin performed an examination to determine the extent of the compensable injury. The maximum allowable reimbursement (MAR) for this examination is $500.00.[1]

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

   Review of the submitted documentation finds that Dr. Erwin performed impairment rating evaluations of the cervical spine and right shoulder with range of motion testing. 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 total MAR for the determination of impairment rating is $450.00.

   Dr. Erwin is seeking reimbursement for the calculation of additional impairment ratings given as part of an examination performed at the request of the insurance carrier. Reimbursement is reserved for multiple impairment ratings performed as part of a **designated doctor**[5] examination. Because this was not performed as a designated doctor examination, no reimbursement can be recommended.

   The total allowable reimbursement for the services in question is $1,300.00. This amount is recommended.

[1] 28 TAC §134.235
[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 §180.22 (h)

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 $1,300.00.

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 $1,300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		August 11, 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.