

## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Joshua Huffman, D.C.

**Respondent Name**

Hartford Casualty Insurance Co.

**MFDR Tracking Number**

M4-21-1991-01

**Carrier's Austin Representative**

Box Number 47

**DWC Date Received**

July 12, 2021

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
October 16, 2020	Designated Doctor Examination (99456-W5-WP, 99456-W6-RE, 99456-W5-MI)	\$1,200.00	\$300.00

### Requestor's Position

"DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED"

**Amount in Dispute:** \$1,200.00

### Respondent's Position

"Upon notification of the dispute, CorVel performed an in-depth review of the DDE medical billing in question. CorVel determined the request for reconsideration for date of service 10/16/20 was timely submitted to the carrier. Therefore, reimbursement is warranted. An immediate re-audit has been requested to allow reimbursement and all accrued interest in accordance with the Act and division rules."

**Response Submitted by:** CorVel

## Findings and Decision

### Authority

This medical fee dispute is decided according to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

### Denial Reasons

The insurance carrier reduced the payment for the disputed services with the following claim adjustment codes:

- 16 – Svc lacks info needed or has billing error(s)
- 252 – Attachment required to adjudicate claim/service
- Notes: "NARRATIVE IS REQUIRED FOR REVIEW"
- Notes: "Only page 1 of narrative submitted. Of the 10 pages faxed to the carrier on 10/29/20: (1 pg) HCFA: (2 pg) DWC69: (3 pgs) DWC68: (1 pg) Genesis Info Sheet: (1pg) Narrative and (1 pg) copy of DWC Memo.

### Issues

1. What are the services considered in this dispute?
2. Is Joshua Huffman, D.C. entitled to additional reimbursement?

### Findings

1. Dr. Huffman is seeking reimbursement for a designated doctor examination that included maximum medical improvement, impairment rating, extent of injury, and multiple calculations of impairment.

Per explanation of benefits dated July 28, 2021, the insurance carrier paid in full for the examination to determine extent of injury and multiple impairment calculations.

The insurance carrier also paid in part for the examination to determine maximum medical improvement and impairment rating. This is the service considered in this dispute.

2. The submitted documentation supports that Dr. Huffman performed an evaluation of maximum medical improvement as ordered by DWC. 28 TAC §134.250 (3)(C) states that the maximum allowable reimbursement (MAR) for this examination is \$350.00.

Review of the submitted documentation finds that Dr. Huffman performed impairment rating evaluations of the lumbar spine with range of motion testing. The rule at 28 TAC §134.250 (4)(C) defines the fees for the calculation of an impairment rating. The MAR for the evaluation of the first musculoskeletal body area performed with range of motion is \$300.00.

The total allowable reimbursement for this examination is \$650.00. The insurance carrier paid \$350.00 for the services in question. An additional reimbursement of \$300.00 is recommended.

### Conclusion

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

DWC finds the requester has established that additional reimbursement of \$300.00 is due.

### **Order**

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is entitled to additional reimbursement for the disputed services. It is ordered that Hartford Casualty Insurance Co. must remit to Joshua Huffman, D.C. \$300.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
September 28, 2021

Date

### **Your Right to Appeal**

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at [www.tdi.texas.gov/forms/form20numeric.html](http://www.tdi.texas.gov/forms/form20numeric.html). DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).