TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Medical Fee Dispute Resolution Findings and Decision

General Information

Requestor Name
John P. Obermiller, M.D.

Respondent Name
United Fire and Casualty Company

MFDR Tracking Number
M4-22-0494-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 8, 2021

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 23, 2021	Required Medical Evaluation 99456-WP	$0.00	$0.00
April 23, 2021	Required Medical Evaluation 99456-WP	$0.00	$0.00
April 23, 2021	Required Medical Evaluation 99456-RE	$0.00	$0.00
April 23, 2021	Required Medical Evaluation 99456-MI	$50.00	$0.00
	Total	$50.00	$0.00

Requestor's Position

We were paid for all portions of the exam except the additional Impairment Rating for accepted and disputed conditions.

Amount in Dispute: $50.00

Respondent's Position

The Austin carrier representative for United Fire and Casualty Company is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on November 16, 2021.

Per 28 Texas Administrative Code §133.307 (d)(1), 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.

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

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:

- 306 – To reprice this code requires the appropriate modifier. Please attach the appropriate modifier and resubmit.
- Notes: "THIS IS REFERENCE TO YOUR APPEAL ON THE ATTACHED CLAIM. YOUR APPEAL HAS BEEN ADDRESSED AND WE HAVE DETERMINED THAT AN ADDITIONAL ALLOWANCE IS WARRANTED."

Issues

1. Is John P. Obermiller, M.D. entitled to additional reimbursement?

Findings

1. Dr. Obermiller is seeking $0.00 for examinations to determine maximum medical improvement, impairment rating, and extent of the compensable injury. Therefore, these services will not be reviewed in this dispute.

   Dr. Obermiller is seeking $50.00 reimbursement for multiple impairments provided as part of a required medical examination requested by the insurance carrier. This service will be reviewed in accordance with the Texas Labor Code and Texas Administrative Code.

   28 TAC §180.22 (h) reserves reimbursement for multiple impairment ratings performed as part of a **designated doctor** examination.

The evidence presented with the dispute request does not support that this service was provided as part of a designated doctor examination. Therefore, no reimbursement can be 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 not established that additional reimbursement is due.

Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 10, 2022 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. 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.

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 electronico CompConnection@tdi.texas.gov.