



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Martin Jones, M.D.

**Respondent Name**

New Hampshire Insurance Co.

**MFDR Tracking Number**

M4-23-1553-01

**Carrier's Austin Representative**

Box Number 19

**DWC Date Received**

March 1, 2023

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
5/21/22	Designated Doctor Examination 99456-W5-WP	\$450.00	\$450.00

### Requestor's Position

MMI = 350.00  
 UE (ROM) = 300.00  
 Spine = 150.00  
 LE = 150.00  
 Skin = 150.00  
 Total = 1,100.00

**Amount in Dispute:** \$450.00

### Respondent's Position

The Austin carrier representative for New Hampshire Insurance Co. is Flahive, Ogden & Latson. The representative was notified of this medical fee dispute on March 7, 2023.

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:

- Workers' compensation jurisdictional fee schedule adjustment.
- The charge for the procedure exceeds the amount indicated in the fee schedule.

### Issues

1. Is Martin Jones, M.D. entitled to additional reimbursement?

### Findings

1. Dr. Jones is seeking additional reimbursement for a designated doctor examination to determine maximum medical improvement and impairment rating.

The submitted documentation supports that Dr. Jones 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. Jones performed impairment rating evaluations of head and face, left shoulder, spine, and right ankle with range of motion testing.

The rule at 28 TAC §134.250 (4)(C)(ii) defines the fees for the calculation of an impairment rating for musculoskeletal body areas. The MAR for the evaluation of the first musculoskeletal body area performed with range of motion is \$300.00. The MAR for the evaluation of subsequent musculoskeletal body areas is \$150.00 each.

The rule at 28 TAC §134.250 (4)(D) defines the fees for the calculation of an impairment rating for non-musculoskeletal body areas. The MAR for the assignment of impairment rating for non-musculoskeletal body areas is \$150.00 each.

The total allowable reimbursement for the examination in question is \$1,100.00. The insurance carrier paid \$650.00. An additional reimbursement of \$450.00 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 \$450.00 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 New Hampshire Insurance Co. must remit to Martin Jones, M.D. \$450.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC §134.130.

### **Authorized Signature**

_____	_____	May 12, 2023
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 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).