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
LOUDEN, KEITH WARD

Respondent Name
STARR INDEMNITY & LIABILITY CO

MFDR Tracking Number
M4-21-0857-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 26, 2021

REQUESTOR'S POSITION SUMMARY

" MMI = $350.00

IR – W/ROM = $300.00

TTL = $650.00"

Amount in Dispute: $300.00

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
August 3, 2020	Designated Doctor Examination (99456-W5-WP)	$300.00	$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 §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Did Starr Indemnity & Liability Company respond to the medical fee dispute?
2. Is Keith Louden, M.D. entitled to reimbursement for the examination in question?

Findings

1. The Austin carrier representative for Starr Indemnity & Liability Company is Flahive Ogden & Latson. The representative was notified of this medical fee dispute on February 2, 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. Dr. Louden is seeking reimbursement for a designated doctor examination performed on August 3, 2020.

   The submitted documentation supports that Dr. Louden performed an evaluation of maximum medical improvement as ordered by the DWC. The maximum allowable reimbursement (MAR) for this examination is $350.00.[2]

   The submitted documentation supports that Dr. Louden provided an impairment rating, which included a musculoskeletal body area, performing a full physical evaluation with range of motion of the left small finger. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[3]

   The total allowable reimbursement is $650.00. The insurance carrier paid $350.00. An additional reimbursement is $300.00 is recommended.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $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 $300.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 4, 2021 Date

[1] 28 TAC §133.307(d)(1)
[2] 28 TAC §134.250(3)(C)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-a-)

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.