



## Medical Fee Dispute Resolution Findings and Decision

### General Information

**Requestor Name**

Keith Louden, M.D.

**Respondent Name**

Lubbock County

**MFDR Tracking Number**

M4-25-1092-01

**Carrier's Austin Representative**

Box Number 43

**DWC Date Received**

January 24, 2025

### Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
April 11, 2024	Designated Doctor Examination 99456-W5-NM	\$50.00	\$50.00
	Designated Doctor Examination 99456-W6-RE	\$500.00	\$500.00
	Designated Doctor Examination 99456-W8-RE	\$250.00	\$250.00
<b>Total</b>		<b>\$800.00</b>	<b>\$800.00</b>

### Requestor's Position

"THE CURRENT RULES ALLOW REIMBURSEMENT"

**Amount in Dispute:** \$800.00

### Respondent's Position

The Austin carrier representative for Keith Louden, M.D. is JI Specialty Services. The representative was notified of this medical fee dispute on February 4, 2025.

Per 28 Texas Administrative Code §133.307(d)(1), if DWC does not receive the response within 14 calendar days of the dispute notification, then 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 \(TLC\) §413.031](#) and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

### Statutes and Rules

1. [28 Texas Administrative Code \(TAC\) §133.307](#) sets out the procedures for resolving medical fee disputes.
2. [28 TAC §134.235, effective July 7, 2016, 41 TexReg 4839](#) sets out the fee guidelines for examinations to determine the extent of a compensable injury and ability to return to work prior to June 1, 2024.
3. [28 TAC §134.240, effective July 7, 2016, 41 TexReg 4839](#) sets out the fee guidelines for designated doctor examinations performed prior to June 1, 2024.
4. [28 TAC §134.250, effective July 7, 2016, 41 TexReg 4839](#) sets out the fee guidelines for examinations to determine maximum medical improvement with dates of service prior to June 1, 2024.

### Denial Reasons

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

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 5141 – Bill has been reviewed by a nurse or under the direction of a nurse.
- 943 – Documentation does not support billed charge. No recommendation of payment can be made.
- 16 – Claim/service lacks information or has submission/billing error(s) which

### Issues

1. Is Keith Louden, M.D. entitled to additional reimbursement for the examination in question?

### Findings

1. Dr. Louden is seeking additional reimbursement for an examination to determine maximum medical improvement, extent of the compensable injury, and ability to return to work.

The submitted documentation supports that Dr. Louden performed an evaluation of maximum medical improvement (MMI) as ordered by DWC. Dr. Louden found that the injured employee was not at MMI. 28 TAC §134.250(3)(C) states that the maximum allowable

reimbursement for this examination is \$350.00. Because the injured employee was found not to be at MMI, no impairment rating was determined.

The submitted documentation indicates that Dr. Louden performed examinations to determine the extent of the compensable injury and ability to return to work. According to 28 TAC §134.235, the MAR for such examinations is \$500.00. Rules for multiple examinations of this type are found at 28 TAC §134.240(2).

Not including maximum medical improvement and impairment rating, when multiple examinations of this type are required, the first examination is reimbursed at 100% of MAR. The second examination is reimbursed at 50%.

For this dispute, the MAR for the examination to determine extent of injury is \$500.00. The examination to determine ability to return to work is \$250.00.

DWC finds that the total allowable reimbursement for the examination in question is \$1,100.00. Per explanation of benefits dated April 25, 2024, the insurance carrier paid \$300.00. An additional reimbursement of \$800.00 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 requestor has established that additional reimbursement of \$800.00 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 Lubbock County must remit to Keith Louden, M.D. \$800.00 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

April 11, 2025  
\_\_\_\_\_  
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 three 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 tres o correo electrónico [CompConnection@tdi.texas.gov](mailto:CompConnection@tdi.texas.gov).