



Medical Fee Dispute Resolution Findings and Decision

General Information

Requester Name

Melburn Huebner, M.D.

Respondent Name

Berkshire Hathaway Homestate

MFDR Tracking Number

M4-26-0580-01

Insurance Carrier's Austin Representative

BOX 12 Shanley Price LLP

DWC Date Received

October 28, 2025

Summary of Findings

| Date(s) of Service | Disputed Services | Amount in Dispute | Amount Due |
|--------------------|--|-------------------|------------|
| May 19, 2025 | Examination to Determine MMI and IR 99456 | \$863.00 | \$398.00 |
| Total | | \$863.00 | \$398.00 |

Requester's Position

The submitted documentation does not include a position statement from the requester. Accordingly, this decision is based on the information available at the time of adjudication.

Amount In Dispute: \$863.00

Respondent's Position

The Austin carrier representative for Berkshire Hathaway Homestate is Shanley Price LLP. The representative was notified of this medical fee dispute on October 31, 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 Section [413.031](#) and other applicable laws and rules of the Texas Department of Insurance, Division of Workers' Compensation (DWC).

Statutes and Rules

1. 28 Texas Administrative Code (TAC) Section [133.307](#) sets out the procedures for resolving medical fee disputes.
2. 28 TAC Section [134.210](#) sets out the fee guidelines for workers' compensation specific services.
3. 28 TAC Section [134.260](#) sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating by a referred doctor.

Adjustment Reasons

The insurance carrier reduced payment for the disputed services with the following reasons:

1. 01 – The charge for the procedure exceeds the amount indicated in the fee schedule.
2. P12TX – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. What is DWC considering in this medical fee dispute?
2. Is the requester entitled to additional reimbursement?

Findings

1. The requester submitted this request for medical fee dispute resolution seeking \$863.00 for an examination to determine maximum medical improvement (MMI) and impairment rating (IR) on behalf of the treating doctor. After this request, the insurance carrier paid \$465.00. DWC will review the remaining balance.
2. Documentation submitted to DWC indicates that the requester determined that the injured employee had reached MMI and provided an impairment rating for a lower extremity.

Per the relevant portion of 28 TAC §134.260(c)(2), "MMI evaluations will be reimbursed at \$449 adjusted per §134.210(b)(4)." The adjusted rate for date of service May 19, 2025, is \$465.00.

28 TAC Section 134.260(c)(3)(A)(i)(I) states, in relevant part, "the reimbursement for the first musculoskeletal body area is \$385 adjusted per §134.210(b)(4)." The adjusted rate for date of service May 19, 2025, is \$398.00.

The total allowable reimbursement for the examination in question is \$863.00. The insurance carrier paid \$465.00. An additional reimbursement of \$398.00 is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence requester and the respondent presented 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 is due.

Order

Under Texas Labor Code Sections [413.031](#) and [413.019](#), DWC has determined the requester is entitled to additional reimbursement for the disputed services. It is ordered that Berkshire Hathaway Homestate must remit to Melburn Huebner, M.D. \$398.00 plus applicable accrued interest within 30 days of receiving this order in accordance with 28 TAC Section [134.130](#).

Authorized Signature

| | | |
|-----------|--|------------------|
| _____ | _____ | February 6, 2026 |
| 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 Section [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 800-252-7031, option three 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 this *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC Section [141.1\(d\)](#).

Si prefiere hablar con una persona en español acerca de esta correspondencia, favor de llamar a 800-252-7031, opción tres o correo electrónico CompConnection@tdi.texas.gov.