



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

Marcus Hayes, D.C.

Respondent Name

Indemnity Insurance Company of North America

MFDR Tracking Number

M4-18-0629-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

November 10, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Regarding the denial in payment, as of September 1, 2011, Sections 408.0041 (f-2) and 408.0041 (h) of the Texas Labor Code require the workers' compensation insurance carrier to pay for treating doctor or referral doctor examinations to certify maximum medical improvement (MMI) and impairment rating (IR) when MMI and IR have first been certified by a designated doctor and the injured employee disagree with the designated doctor's opinion. Additionally, MMI certification evaluations do not require pre-authorization by Rule 134.600 because this is an examination and not treatment."

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Because the first rating and PLN3, sent 5/3/17, became final with no dispute, the examination from Requestor was not required ... It is the Requestor's position this examination, not ordered by TDI-DWC, and not addressed in the ODGs, required preauthorization."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: October 11, 2017, Referral Examination to Determine Maximum Medical Improvement and Impairment Rating, \$650.00, \$500.00

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.

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 performed on or after September 1, 2016.

3. 28 Texas Administrative Code §134.235 sets out the fee guidelines for return to work examinations performed on or after September 1, 2016.
4. Texas Labor Code §408.0041 sets out the requirements for designated doctor examinations.
5. Texas Labor Code §408.123 addresses the finality of determinations of maximum medical improvement and impairment rating.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers’ compensation jurisdictional fee schedule adjustment.
 - 5264 – Payment is denied-service not authorized.
 - 309 – The charge for this procedure exceeds the fee schedule allowance.
 - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
 - 247 – A payment or denial has already been recommended for this service.

Issues

1. Is the insurance carrier’s reason for denial of payment for the disputed service supported?
2. Is Marcus Hayes, D.C. entitled to reimbursement for the disputed services?

Findings

1. Dr. Hayes is seeking reimbursement of \$650.00 for an examination to determine maximum medical improvement (MMI) and impairment rating (IR) performed on October 11, 2017. Indemnity Insurance Company of North America denied the disputed service with claim adjustment reason code 5264 – “Payment is denied-service not authorized,” with further comment, “Because the first rating and PLN3, sent 5/3/17, became final with no dispute, the examination from Requestor was not required ... It is the Requestor’s position this examination, not ordered by TDI-DWC, and not addressed in the ODGs, required preauthorization.”

Texas Labor Code §408.0041(f-2) provides the circumstances under which the injured employee may seek an examination by a doctor other than the designated doctor. TLC §408.123(f) addresses the exceptions to the requirement to dispute of the certification of MMI and IR within 90 days.

The division finds that the insurance carrier failed to demonstrate that the examination in question did not meet the standards put forth in TLC §408.0041(f-2) and TLC §408.123(f).

TLC §408.0041(h)(1) requires the insurance carrier to reimburse an examination performed under Subsection (f-2), unless otherwise prohibited. The division concludes that the examination in question was not prohibited by the Labor Code, an order, or rule of the commissioner. Therefore, the insurance carrier’s denial of this examination is not supported.

2. Because the insurance carrier failed to support its denial of the disputed service, Dr. Hayes is entitled to reimbursement as follows:

Per 28 Texas Administrative Code §134.250(3), reimbursement for an examination to determine MMI is \$350.00. The submitted documentation supports that Dr. Hayes performed an MMI evaluation. Therefore, the maximum allowable reimbursement (MAR) for this examination is \$350.00.

Per 28 TAC §134.250(4), reimbursement for an IR of a musculoskeletal body area that includes a full physical examination with range of motion is \$300.00. The submitted documentation supports that Dr. Hayes provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the lumbar spine. Therefore, the MAR for this examination is \$300.00.

The MAR for the disputed examination is \$650.00. Dr. Hayes billed \$500.00 to the insurance carrier. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$500.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor \$500.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature

Laurie Garnes
Medical Fee Dispute Resolution Officer

May 22, 2018
Date

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 division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division 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.