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
David West, D.O.

Respondent Name
East TX Educational Insurance Association

MFDR Tracking Number
M4-19-2697-01

Carrier's Austin Representative
Box Number 17

MFDR Date Received
January 15, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance carrier is liable to pay for MMI/IR examinations regardless of network standing, because the certification was at the request of the patients treating doctor."

Amount in Dispute: $950.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… I have attached copies of the CCH decision and AP Decision which became final on 7/28/17. It is our position that the Impairment Rating rendered by Dr. West was not reasonable and necessary and that denial should be maintained."

Response Submitted by: Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 20, 2018	Examination to Determine Maximum Medical Improvement and Impairment Rating	$950.00	$0.00

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. Texas Labor Code §408.0041 sets out the requirements for designated doctor examinations.
3. Texas Labor Code §408.123 sets out the requirements for certification of maximum medical improvement and impairment rating.
4. Texas Labor Code §410.205 sets out the effect of an appeals panel decision.
5. Texas Labor Code §410.251 sets out the manner of dispute when a party disagrees with an appeals panel

decision.

6. Texas Labor Code §410.255 sets out the procedure for judicial review of a contested case.
7. Texas Labor Code §410.307 provides that the designated doctor may present another impairment in the case of a substantial change of condition.
8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 304 – MMI or IR certification is not valid for this date of service.
   - B7 – This provider was not certified/eligible to be paid for this procedure/service on this date of service.
   - Notes: "Per the 05/24/17 CCH D&O the clmt was at MMI 07/24/16 with 3% IR and rating has become final. There is no avenue to challenge this rating."

Issues

Are the insurance carrier's reasons for denial of payment supported for the examination in question?

Findings

David West, D.O. is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating performed on June 20, 2018. The insurance carrier denied payment stating that "This provider was not certified/eligible to be paid for this procedure/service on this date of service" based on a contested case hearing decision and order.

The insurance carrier provided documentation that the injured employee was certified at maximum medical improvement as of July 24, 2016 with an impairment rating of 3% by Designated Doctor Marc D. Pecha on October 20, 2016.

The injured employee disputed the designated doctor's findings and a contested case hearing decision and order was issued on May 31, 2017 affirming the findings of Dr. Pecha. This decision was upheld by appeals panel decision issued July 28, 2017.

Further dispute of Dr. Pecha's findings must be in accordance with TLC §410.251. The examination in question was requested by the injured employee's treating doctor. Dr. West is not eligible for reimbursement of the examination in question as it does not meet the requirements of the applicable rules and statutes. The insurance carrier's position is supported.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	March 7, 2019
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 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.