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
TEXAS IMPAIRMENT EXAM

Respondent Name
EMPLOYERS PREFERRED INS CO

MFDR Tracking Number
M4-20-0302-01

Carrier's Austin Representative
Box Number 4

MFDR Date Received
October 1, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I performed this examination at the request of the injured employee and the treating doctor."

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The exam was not authorized and there is no documentation from the treating physician indicating the employee was referred for an impairment rating exam. Please see the attached chart notes and request for authorization from the treating physician Dr. Gist on 11/14/2018 showing the claimant was still in need of active medical care and therapy to assist with his recovery."

Response Submitted by: EIG Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 28, 2018	Examination to Determine Maximum Medical Improvement	$350.00	$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 (DWC).

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §130.1 sets out the authorization requirements for examinations to certify maximum medical improvement and impairment rating.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 6532 – Absence of, or exceeds, pre-certification/authorization

Issues

Is the insurance carrier's reason for denial of payment supported?

Findings

Texas Impairment Exam is seeking reimbursement for an examination to determine maximum medical improvement performed by Dr. Trenton Weeks on November 28, 2018. The insurance carrier denied payment for the examination based on authorization.

Dr. Weeks stated that the examination was performed "at the request of the injured employee and the treating doctor." The insurance carrier provided evidence to support that the treating physician had not referred the injured employee for an examination to determine maximum medical improvement.

The requestor has the burden to support that it is entitled to the reimbursement requested. Upon receipt of the insurance carrier's response to this dispute, Texas Impairment Exam failed to refute the insurance carrier's argument.

Therefore, based on the submitted evidence, the DWC concludes that the insurance carrier's denial reason is supported. No reimbursement is recommended.

Conclusion

For the reasons stated above, the DWC 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 DWC hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	November 15, 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 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.