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
BURRIS, BENJAMIN S.

Respondent Name
IMPERIUM INSURANCE CO

MFDR Tracking Number
M4-20-2129-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 4, 2020

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CERTIFYING DOCTOR EXAMINATION NO PAYMENT RECEIVED"

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is the carrier's position that the provider is not entitled to reimbursement. The carrier's EOBs explain the carrier's position."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 24, 2020	Examination to Determine Maximum Medical Improvement and Impairment Rating	$650.00	$650.00

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 §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15 – Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
   - 6612 – Per the adjuster, this date of service is denied.
   - W3 – Additional payment made on appeal/reconsideration.
   - 131 – claim specific negotiated discount.

- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 272 – Service reviewed per client instructions.
- 1014 – The attached billing has been re-evaluated at the request of the provider. Based on this re-evaluation we find our original review to be correct. Therefore, no additional allowance appears to be warranted.

Issues

1. Are Imperium Insurance Company's reasons for denial of payment supported?
2. Is Benjamin S. Burris, M.D. entitled to reimbursement for the examination in question?

Findings

1. Dr. Burris is seeking reimbursement for an examination to determine maximum medical improvement (MMI) and impairment rating (IR).

   The insurance carrier denied payment, in part based on preauthorization. Examinations to determine MMI and IR do not require preauthorization.[1] This reason for denial of payment is not supported.

   The insurance carrier also denied payment stating, "Per the adjuster, this date of service is denied." The insurance carrier provided no basis for this denial, either on the explanations of benefits, or in its position statement. The DWC concludes that this denial reason is not supported.

2. Because the insurance carrier failed to support its denial of payment for the examination in question, Dr. Burris is entitled to reimbursement.

   The submitted documentation supports that Dr. Burris performed an evaluation of maximum medical improvement. The maximum allowable reimbursement (MAR) for this examination is $350.00.[2]

   The submitted documentation supports that Dr. Burris provided an impairment rating for a musculoskeletal body area, performing a full physical evaluation with range of motion of the lumbar spine. Reimbursement is $300.00 for the first musculoskeletal body area if a full physical evaluation with range of motion is performed.[3]

   The total allowable amount for this examination is $650.00. This amount is recommended.

Conclusion

For the reasons stated above, the DWC finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $650.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the DWC has determined the requestor is entitled to additional reimbursement for the disputed services. The DWC hereby ORDERS the respondent to remit to the requestor $650.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 8, 2020 Date

[1] 28 TAC §134.600
[2] 28 TAC §134.250(3)(C)
[3] 28 TAC §134.250(4)(C)(ii)(II)(-a-)

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.