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
XL INSURANCE AMERICA INC

MFDR Tracking Number
M4-21-1792-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 7, 2021

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This evaluation and report do not in any way constitute treatment of the injured worker and is not subject to preauthorization requirements"

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider's CMS-1500 is illegible. We are attaching a copy of it. We are also attaching a copy of the carrier's EORs dated September 24, 2020 and January 15, 2021. The provider is not entitled to reimbursement."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 26, 2020	Examination to Determine Maximum Medical Improvement and Impairment Rating (99456-NM)	$350.00	$350.00

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 §130.1 sets out the regulations regarding certification of maximum medical improvement and impairment rating.
2. 28 Texas Administrative Code §130.2 sets out the procedures for certification of maximum medical improvement and impairment rating by a treating doctor.
3. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
4. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum medical improvement and impairment rating.

5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 247 – A payment or denial has already been recommended for this service.
   - 5264 – Payment is denied-service not authorized.
   - 18 – Exact duplicate claim/service.
   - 197 – Payment denied/reduced for absence of precertification/authorization.
   - N111 – No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
   - 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.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - W3 – Additional payment made on appeal/reconsideration.

Issues

1. Is XL Insurance America, Inc.'s denial of payment based on duplicate claim or service supported?
2. Is XL Insurance America, Inc.'s denial of payment based on preauthorization supported?
3. Is Texas Impairment Exam entitled to payment for the examination in question?

Findings

1. Texas Impairment Exam is seeking reimbursement for an examination to determine maximum medical improvement and impairment rating. The insurance carrier denied payment, in part, stating, "This service was included in a claim that has been previously billed and adjudicated."

   The DWC found no evidence submitted to support this statement. The DWC finds that the denial based on duplicate claim or service is not supported.

2. XL Insurance America, Inc. also denied payment based on preauthorization. An examination to determine maximum medical improvement and impairment rating is a division-specific service.

   The treating doctor may refer an injured employee to another doctor to evaluate if the injured employee has reached maximum medical improvement and calculate an impairment rating.[1] The referral doctor is then authorized to perform the examination if he is certified by the DWC.[2]

   Submitted evidence supports that Trenton Weeks, D.C. was authorized and certified to perform the examination in question. The insurance carrier's denial for this reason is not supported.

3. Because the insurance carrier failed to support its denial of payment for the examination in question, Texas Impairment Exam is entitled to reimbursement for the examination in question.

   The submitted documentation supports that Dr. Weeks performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement for this examination is $350.00.[3] This amount is recommended.

Conclusion

The outcome of each independent medical fee dispute relies upon the relevant evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence in this dispute may not have been discussed, it was considered. For the reasons stated above, the Texas Department of Insurance, Division of Workers' Compensation (DWC) finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $350.00.

[1] 28 TAC §130.2 (a)(1)
[2] 28 TAC §130.1 (a)(1)(A)(i)
[3] 28 TAC §134.250(3)(C)

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 $350.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

		July 9, 2021
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.