



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

Thomas Pfeil, Jr., M.D.

Respondent Name

ACE American Insurance Company

MFDR Tracking Number

M4-16-0289-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

October 2, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "AN ORIGINAL BILL AND A RECONSIDERATION WERE SUBMITTED, THE CURRENT RULES ALLOW REIMBURSEMENT."

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CorVel determined that the requestor's initial submission of billing was faxed on 03/05/15 to an unknown fax number not associated with CorVel. A subsequent submission of billing was submitted on 05/01/15 was not processed as it was inadvertently lost due to electronic facsimile software issues."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: February 26, 2015, Designated Doctor Examination, \$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.

Background

- 1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 defines the requirements for a complete medical bill.
3. 28 Texas Administrative Code §133.20 sets out the procedures for submitting a medical bill.
4. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes: Submitted documentation does not include an explanation of benefits.

Issues

1. Does a denial of payment exist for this dispute?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation supports that the requestor timely submitted a complete medical bill to the insurance carrier. Submitted documentation does not support that the insurance carrier denied the services in question. In their position statement, the insurance carrier states, "... CorVel is recommending payment plus accrued interest in accordance with the Act and division rules." The division finds that no denial of payment exists for this dispute. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
2. Per 28 Texas Administrative Code §134.204 (j)(3), "The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." The submitted documentation indicates that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is \$350.00.

Per 28 Texas Administrative Code §134.204 (j)(4), "The following applies for billing and reimbursement of an IR evaluation. ... (C)(ii) The MAR for musculoskeletal body areas shall be as follows. ... (II) If full physical evaluation, with range of motion, is performed: (-a-) \$300 for the first musculoskeletal body area." The submitted documentation indicates that the requestor provided an impairment rating, which included a musculoskeletal body part, and performed a full physical evaluation with range of motion of the left upper extremity. Therefore, the correct MAR for this examination is \$300.00.
3. The total MAR for the disputed services is \$650.00. The insurance carrier paid \$0.00. A reimbursement of \$650.00 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 \$650.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$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

Laurie Garnes
Medical Fee Dispute Resolution Officer

December 30, 2015
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 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 with the Division. **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.