



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

James Wetz, D.C.

Respondent Name

Insurance Company of the State of Pennsylvania

MFDR Tracking Number

M4-16-2577-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

April 26, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: \$650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "... there has been no proof submitted by the Requestor that the billing was submitted to Corvel within 95 days of the DOS (original billing) or within 10 months of the DOS (reconsideration)..."

Response Submitted by: CorVel Healthcare Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 12, 2015	Designated Doctor	\$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

- 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
- 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
- The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - 150 – Payment adjusted/unsupported service level
 - Notes: "DWC 69 NOT SUBMITTED"

Issues

1. What are the services in dispute?
2. Does an issue of timely filing exist for this dispute?
3. Is the insurance carrier's reason for denial of payment supported?
4. What is the maximum allowable reimbursement (MAR) for the disputed services?
5. Is the requestor entitled to additional reimbursement?

Findings

1. The original Medical Fee Dispute Resolution Request (DWC060) included designated doctor examinations to determine if the injured employee had reached maximum medical improvement, the impairment rating, and the ability of the injured employee to return to work. After, received a partial payment based on an Explanation of Review, dated April 28, 2016, the requestor amended their request to included only designated doctor examinations to determine if the injured employee had reached maximum medical improvement and the impairment rating. Therefore, these are the only services considered for this dispute.
2. In their position statement, the respondent states that the "Respondent/TPA never received the original billing nor the Request for Reconsideration," and "there has been no proof submitted by the Requestor that the billing was submitted to Corvel within 95 days of the DOS..." 28 Texas Administrative Code §133.307(d)(2)(F) states, in relevant part:

The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review.

Review of the submitted information finds that an issue of timely filing was not presented to the requestor prior to the date the request for MFDR was filed. Therefore, this issue will not be considered for this dispute.

3. The insurance carrier denied disputed services with claim adjustment reason code 150 – "Payment adjusted/unsupported service level" and stating "DWC 69 NOT SUBMITTED." 28 Texas Administrative Code §134.204(j)(1) requires the preparation and submission of reports for an examination to determine maximum medical improvement and impairment rating. Review of the submitted documentation finds a Report of Medical Evaluation (DWC069) was included. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.
4. 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 supports 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 supports 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 right lower extremity. Therefore, the correct MAR for this examination is \$300.00.
5. The total MAR for the disputed services is \$650.00. The insurance carrier paid \$0.00 for the services in question. An additional 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 in 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

_____	<u>Laurie Garnes</u>	<u>May 25, 2016</u>
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 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.