



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

Patient Care Injury Clinic, P.A.

Respondent Name

Markel Insurance Company

MFDR Tracking Number

M4-16-2665-01

Carrier's Austin Representative

Box Number 17

MFDR Date Received

May 4, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier processed one HCFA and not the other for payment."

Amount in Dispute: \$170.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent has paid the Provider for the services billed on 7/10/15. Payment was issued on 2/2/16, prior to the provider filing this request for medical fee dispute resolution."

Response Submitted by: Downs-Stanford, P.C.

SUMMARY OF FINDINGS

Table with 4 columns: Dates of Service, Disputed Services, Amount In Dispute, Amount Due. Row 1: July 10, 2015, Physical Therapy, \$170.84, \$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.

Background

- 1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
• 663 – Reimbursement has been calculated according to the state fee schedule guidelines.

Issues

Is the requestor entitled to additional reimbursement?

Findings

The requestor is seeking reimbursement for physical therapy performed on July 10, 2015. Review of the submitted documentation finds an explanation of benefits dated January 29, 2016 indicating reimbursement of the full amount sought by the requestor. Therefore, the division finds that the requestor is not entitled to additional reimbursement for the services in this dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	August 11, 2016
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.