



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

John Sklar, M.D.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-16-2883-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

May 20, 2016

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: \$1000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requester's narrative report of MMI/IR is dated 8/27/15 and states in part, 'I had the opportunity to see [injured employee] in my ... office on August 27, 2015...' However, both the requestor's bill and DWC69 indicate the exam date was 9/16/15. Absent any clarification from the requestor Texas Mutual declined to issue payment for the inconsistency."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 16, 2015	Designated Doctor Examination	\$1000.00	\$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

- 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:
 - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.
 - CAC-16 – Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.

- 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
- CAC-138 – Appeal procedures not followed or time limits not met.
- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- CAC243 – Services not authorized by network/primary care providers.
- 724 – No additional payment after a reconsideration of services.
- 727 – Provider not approved to treat Texas Star Network claimant.
- 879 – Rule 133.250(b) – Health care provider shall submit the request for reconsideration no later than 10 months from the date of service.

Issues

Is the insurance carrier’s reason for denial of payment supported?

Findings

The requestor is seeking reimbursement for a designated doctor examination to determine maximum medical improvement (MMI) and impairment rating (IR) which includes the findings from a referred specialist’s report. The date of service in dispute is September 16, 2015. The insurance carrier denied disputed services with claim adjustment reason code 225 – “THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED...”

28 Texas Administrative Code §134.204(j)(1) requires preparation and submission of reports, including a narrative report. Review of the submitted information finds that the date of service provided in the narrative report is August 27, 2015. The division finds that the insurance carrier’s denial reason is supported. Additional reimbursement cannot be recommended.

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	June 22, 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.