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
David A West DO

Respondent Name
Zurich American Insurance Co

MFDR Tracking Number
M4-16-3114-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
June 13, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "However, in this case the provider billed an Office Consult that took into consideration a comprehensive history, a comprehensive evaluation and medical decision making of high complexity. Determining the examinee's need for surgical intervention is a moderate severity as demonstrated in the original medical report. The claim was billed at the lesser amount for Office Consultation however, Evaluation of Medical Care was performed and can be billed at a much higher rate."

Amount in Dispute: $260.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "At this time, CV cannot recommend any additional allowance for the office visit based on the Detailed vs Comprehensive history."

Response Submitted by: Gallagher Bassett Services

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 8, 2016	99204	$260.24	$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. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 15 – (150) – Payer deems the information submitted does not support this level of service
   - BL – This bill is a reconsideration of a previously reviewed bill. Allowance amount do not reflect previous payments

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The carrier denied the disputed service as 150 – "Payer deems the information submitted does not support this level of service." Review of the submitted document titled, "Orthopedic Consultation" finds the following:

Required Element	Submitted Documentation Findings	Requirement of Code Met
Comprehensive History	History of Present illness – 1 condition Review of systems – Musculoskeletal Past Medical History	No – Report supports Expanded Problem Focused
Comprehensive Examination	Body Areas – Neck, Right Shoulder	No – Report supports Expanded Problem Focused
Moderate complexity medical decision making	Number of Diagnoses or Treatment options – 1 Amount and/or Complexity of Data Reviewed – 1 (Discussion of test results) Risk of Significant Complications, Morbidity, and/or Mortality - Low	No – Reports supports Straightforward

Based on the above, the carrier's denial is supported.

2. Pursuant to Division Rule 134.203(b) not additional payment is due.

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

		July , 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.