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
Mark Johnson, M.D.

Respondent Name
American Zurich Insurance Company

MFDR Tracking Number
M4-16-3706-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
August 16, 2016

REQUESTOR'S POSITION SUMMARY

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

Amount in Dispute: $350.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "On 10/06/15 CorVel received a copy of the CMS-1500 bill from the prior TPA, York Services with no documentation attached."

Response Submitted by: CorVel

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 25, 2015	Designated Doctor Examination (99456-W5-NM)	$350.00	$350.00

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 §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 105 – Additional information needed to review charges
   - 16 – Svc lacks info needed or has billing error(s)
   - 182 – Reviewed as No Charge

Issues

1. Are the insurance carrier's reasons for denial of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code 105 – "Additional information needed to review charges," and 16 – "Svc lacks info needed or has billing error(s)." In its position statement, the insurance carrier clarified by stating, "On 10/06/15 CorVel received a copy of the CMS-1500 bill from the prior TPA, York Services with no documentation attached."

   Review of the submitted information finds the following:

   - A fax confirmation sheet submitted by the requestor, dated September 2, 2015, supports submission of a medical bill and narrative report for the services in question, and
   - A copy of the date-stamped medical bill indicating that it was page 2 of an 8-page fax, supporting that the report was attached to the billing.

   The division finds that the evidence supports that the requestor submitted the required report with the billing. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.204(j)(2)(A),

   > If the examining doctor, other than the treating doctor, determines MMI has not been reached, the MMI evaluation portion of the examination shall be billed and reimbursed in accordance with paragraph (3) of this subsection. Modifier "NM" shall be added.

   Paragraph (3) states, "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 MMI and found that the injured employee was not at MMI. Therefore, the correct MAR for this examination is $350.00.

3. The total MAR for the disputed service is $350.00. The insurance carrier paid $0.00. A reimbursement of $350.00 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 $350.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 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 $350.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	August 31, 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.