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
Larry C. Stetzner, M.D., Ph.D.

Respondent Name
Arch Insurance Company

MFDR Tracking Number
M4-18-0135-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 15, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Submitted documentation does not include a position statement from the requestor. Accordingly, this decision is based on the information available at the time of review.

Amount in Dispute: $800.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS Med Bill Impact's Bill Review Department reviewed the above mentioned date of service and found that the provider was not due additional money. It has been determined that ESIS Med Bill Impact will stand on the original recommendation of $0.00."

Response Submitted by: ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 10, 2017	Referral Doctor Examination to Determine Maximum Medical Improvement & Impairment Rating	$800.00	$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

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 sets out the procedures for completing a medical bill.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 418 – Resubmit bill with appropriate ICD-10 diagnosis codes: S8001X is invalid
   - 146 – Diagnosis was invalid for the date(s) of service reported.

Issues

Are Arch Insurance Company's reasons for denial of payment supported?

Findings

Larry C. Stetzner, M.D., Ph.D. is seeking reimbursement of $800.00 for an examination requested by the injured employee and referred by the treating doctor to determine maximum medical improvement and impairment rating. Arch Insurance Company denied the services in question with claim adjustment reason codes 418 – "Resubmit bill with appropriate ICD-10 diagnosis codes: S8001X is invalid," and 146 – "Diagnosis was invalid for the date(s) of service reported."

28 Texas Administrative Code §133.10(f)(1)(M) requires the applicable ICD indicator for the diagnosis or nature of injury. The division finds that S80.01X is not an ICD-10 indicator. The division concludes that Arch Insurance Company's reasons for denial of payment are supported.

Conclusion

The outcome of this medical fee dispute relied upon the evidence presented by the requestor and the respondent at the time of adjudication. Though all the evidence may not have been discussed, it was considered. 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 on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	October 19, 2017
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 Rule §133.307, effective May 31, 2012, *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. **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.