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 STETZNER MD

Respondent Name
ACE AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-20-0619-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
November 4, 2019

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The reasoning for non-payment is 'provider not certified to establish impairment ratings.'… Dr. Stetzner is a certified provider."

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill has been reviewed and adjusted for payment – copies of EOBs are submitted for your review."

Response Submitted by: Helmsman Management Services LLC

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
August 02, 2019	99456	$650.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code (TLC) §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code (TAC) §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 TAC §134.203 sets out the fee guideline for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - W3 – Additional payment made on appeal/reconsideration

Issues

1. Did the insurance carrier issue payment for the disputed service rendered on August 22, 2019?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 99456 rendered on, August 02, 2019. Per 28 TAC §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors and shall be effective January 1st of the new calendar year."

   Per 28 TAC §134.203 "(h) When there is no negotiated or contracted amount that complies with TLC §413.011, reimbursement shall be the least of the: (1) MAR amount; (2) health care provider's usual and customary charge, unless directed by Division rule to bill a specific amount; or (3) fair and reasonable amount consistent with the standards of §134.1 of this title."

   The requestor seeks a reimbursement amount of $650.00. Review of the EOB dated November 20, 2019 submitted by the insurance carrier supports that a payment in the amount of $650.00 was issued to the requestor, for disputed date of service, August 02, 2019, under check #0083470063. As a result, the requestor is not entitled to additional reimbursement for the disputed CPT code, 99456.

2. Review of the submitted documentation finds that the requestor is not entitled to additional reimbursement for CPT Code 99456 rendered in August 02, 2019.

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 TLC §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 24, 2020 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 TAC §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 MDR 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 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.