TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

# Medical Fee Dispute Resolution Findings and Decision

## General Information

**Requestor Name**
Doctors Hospital at Renaissance

**Respondent Name**
Protective Insurance Co

**MFDR Tracking Number**
M4-22-0491-01

**Carrier's Austin Representative**
Box Number 17

**DWC Date Received**
November 8, 2021

## Summary of Findings

| Dates of Service | Disputed Services | Amount in Dispute | Amount Due |
|---|---|---|---|
| July 23, 2021 | G0463 | $213.48 | $0.00 |
| | **Total** | $213.48 | $0.00 |

## Requestor's Position

The requestor did not submit a position statement but did submit a copy of their reconsideration that states "Per your EOR denial claim was billed with incorrect CPT codes; attached you will find corrected claim along with the medical records, itemized statement and EOB for your review."

**Amount in Dispute:** $213.48

## Respondent's Position

CorVel will maintain the requestor, Doctors Hospital at Renaissance is not entitled to reimbursement for the date of service 06/25/21 in the amount of $241.64 based on incorrect coding per CMS guidelines. CorVel further notes the requestor has failed to submit a medical bill to the insurance carrier for the HCPCS Code G0463 listed on the DWC-60 prior to submission of the request for medical dispute resolution.

## Findings and Decision

Authority

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

Statutes and Rules

1. 28 TAC §133.307 sets out the procedures for resolving medical fee disputes.

Denial Reasons

The requestor submitted explanation of benefits for dates of service June 25, 2021, for code 99213. No explanation of benefits was submitted for the code G0463 for date of service July 23, 2021, as listed on the DWC-60.

Issues

1. Did the requestor comply with requirements of Rule 133.307?

Findings

1. The requestor is seeking reimbursement of outpatient hospital services rendered July 2021. However, the submitted medical bill and explanation of benefits were for a different code and date of service in June 2021.

   DWC Rule §133.307 (2)(J)(K) states in pertinent part the requestor must send the request to the division in the form and manner prescribed by the division by any mail service, personal delivery, or electronic transmission as described in §102.5 of this title. The request must include:

   > (J) a copy of all medical bills related to the dispute, as described in §133.10 of this chapter (concerning Required Billing Forms/Formats) or §133.500 (concerning Electronic Formats for Electronic Medical Bill Processing) as originally submitted to the insurance carrier in accordance with this chapter, and a copy of all medical bills submitted to the insurance carrier for an appeal in accordance with §133.250 of this chapter (concerning Reconsideration for Payment of Medical Bills);
   >
   > (K) each explanation of benefits or e-remittance (collectively "EOB") related to the dispute as originally submitted to the health care provider in accordance with this chapter or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB

   Review of the submitted medical bill and explanation of benefits is insufficient to support the request for medical fee dispute resolution of date of service July 23, 2021, for code G0463. No payment is recommended.

Conclusion

The outcome of this medical fee dispute is based on the evidence presented by the requestor and the respondent at the time of adjudication. Though all evidence may not have been discussed, it was considered.

DWC finds the requester has not established that additional reimbursement is due.

## Order

Under Texas Labor Code §§413.031 and 413.019, DWC has determined the requestor is not entitled to additional reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | March 7, 2022<br>Date |
|---|---|---|

## Your Right to Appeal

Either party to this medical fee dispute has a right to seek review of this decision under 28 TAC §133.307, which applies to disputes filed on or after **June 1, 2012**.

A party seeking review must submit DWC Form-045M, *Request to Schedule, Reschedule, or Cancel a Benefit Review Conference to Appeal a Medical Fee Dispute Decision (BRC-MFD)* and follow the instructions on the form. You can find the form at www.tdi.texas.gov/forms/form20numeric.html. DWC must receive the request within **20 days** of when you receive this decision. You may fax, mail, or personally deliver your request to DWC using the contact information on the form or the field office handling the claim. If you have questions about DWC Form-045M, please call CompConnection at 1-800-252-7031, option 3 or email CompConnection@tdi.texas.gov.

The party seeking review of the MFDR decision must deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with DWC. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** with any other required information listed in 28 TAC §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 1-800-252-7031, opción 3 o correo electronico CompConnection@tdi.texas.gov.