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
Lankford Hand Surgery Assn

Respondent Name
Arch Indemnity Insurance Co

MFDR Tracking Number
M4-23-0563-01

Carrier's Austin Representative
Box Number 19

DWC Date Received
November 2, 2022

Summary of Findings

Dates of Service	Disputed Services	Amount in Dispute	Amount Due
March 22, 2022	20670	$799.20	$0.00
	Total	$799.20	$0.00

Requestor's Position

The requestor did not submit a position statement with this request for medical fee dispute resolution,

Amount in Dispute: $799.20

Respondent's Position

The Austin carrier representative for Arch Indemnity Insurance Co is Flahive Ogden and Latson. The representative was notified of this medical fee dispute on November 8, 2022.

Per 28 Texas Administrative Code §133.307(d)(1), if the DWC does not receive the response within 14 calendar days of the dispute notification, then the DWC may base its decision on the available information.

As of today, no response has been received from the insurance carrier or its representative. We

will base this decision on the information available.

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.

2. 28 TAC §134.203 sets out the billing requirements of professional medical fees.

Denial Reasons

The insurance carrier reduced or denied the disputed service(s) with the following claim adjustment codes.

- P12 – Workers' Compensation Jurisdictional Fee Schedule Adjustment
- 107 – Claim/service denied because the related or qualifying claim/service was not previously paid or identified on this claim
- 5347 – CV: Documentation on the CMS 1500 or uB04 is not supported by the information in the medical record
- 00663 – Reimbursement has been calculated according to State Fee Schedule Guidelines
- 90223 – Workers' Compensation Jurisdictional Fee Schedule Adjustment
- B12-1 – Services not documented in patients' medical records
- 247 – Payment or denial has already been recommended for this service

Issues

1. Is the insurance carrier's denial supported?

Findings

1. The requestor is seeking reimbursement of Code 20670 – Removal implant superficial separate procedure. The submitted medical bill and chart note indicate date of service March 22, 2022. The original explanation of benefits referenced date of service March 2, 2022 but the reconsideration explanation of benefits indicates date of service March 22, 2022. The insurance carrier denied as services not documented.

   Review of the submitted office visit found the comment, "I will remove one K wire today and ask permission to remove the other K wire. When it comes to the surface, we will remove it at

four weeks."

This documentation does not support a separate procedure to remove the implant was done. The insurance carrier's denial is supported. No payment 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	April 14, 2023 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.