Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address
MARC T TAYLOR MD

Respondent Name
HARTFORD UNDERWRITERS INSURANCE

MFDR Tracking Number
M4-06-5203-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
February 21, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Updated Position Summary dated August 19, 2008: "After reviewing all the records and payments to date the following is an accurate description of the charges and payments received. For 2/23/05 of the $2150, charged payments received total $1720. The following payments were received on 2/11/08 for $843.75 and on 5/5/08 for $876.25. Leaving a balance of $430.00."

Amount in Dispute: $430.00 (Correct Table Total $578.04)

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "MDR-M4-06-5203-01 payment summaries. Please let me know if you have any questions."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 24, 2005	99232	$95.86	$0.00
February 25, 2005	99232	$73.79	$0.00
February 25, 2005 and March 9, 2005	99371	$105.06	$0.00
February 26, 2005	99232	$95.86	$0.00
February 27, 2005	99232	$95.86	$0.00
February 28, 2005	99239	$108.59	$0.00
March 9, 2005	99213	$3.02	$0.00
TOTAL		$578.04	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted 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 a medical fee dispute.
2. 28 Texas Administrative Code §134.202 sets out the medical fee guidelines for professional services provided between August 1, 2003 and March 1, 2008.
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. This request for medical fee dispute resolution was received by the Division on February 21, 2006. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on April 14, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W1 – WC state fee sched adjust. Reimbursement according to the Texas medical fee guideline.
   - 97 – Payment is incl in the allow for another srvc. The srvcs listed under this procedure code are included in a more comprehensive code which accurately describes the entire procedure(s) performed.
   - W3 – Additional payment made on appeal/reconsideration. Reimbursement for your resubmitted invoice is based upon documentation and/or additional information provided.

Issues

1. Did the requestor submit an updated table of disputed services on August 19, 2008?
2. Did the requestor submit documentation to support fair and reasonable reimbursement for CPT code 99371 rendered on February 25, 2005 and March 9, 2005?
3. Did the insurance carrier issue payments for the remaining disputed charges?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation date August 19, 2008 by Maggie Taylor, supports that the insurance carrier issued payments for the majority of the disputed charges. The requestor disputes CPT codes 99232, 99371, 99213 and 99239 rendered February 24, 2005 through March 9, 2005. The division will therefore review only the charges indicated in the letter submitted by Maggie Taylor on August 19, 2008.
2. This dispute relates to a service (CPT code 99371 rendered on February 25, 2005) with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   Former 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor did not submit documentation to support that additional payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement for CPT code 99371 rendered on February 25, 2005 is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that additional payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Therefore, additional reimbursement cannot be recommended.

3. Per 28 Texas Administrative Code §134.202 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

   Per 28 Texas Administrative Code §134.202 "(c) To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%. For Anesthesiology services, the same conversion factor shall be used."

   Review of the submitted documentation finds that the requestor is entitled to the MAR reimbursement for the disputed charges as follows:

   Date of service, February 24, 2005, CPT code 99232, and the Medicare reimbursement is $54.14 x 125% equals a MAR reimbursement of $67.68. Review of the submitted documentation supports that the insurance carrier issued payment in the amount of $67.68. The requestor is therefore not entitled to additional reimbursement for CPT code 99232.

   Date of service, February 25, 2005, CPT code 99232, the Medicare reimbursement for CPT code 99232 is $54.14 x 125% equals a MAR reimbursement of $67.68. Review of the submitted documentation supports that the insurance carrier issued payment in the amount of $67.68. The requestor is therefore not entitled to additional reimbursement for CPT code 99232.

   Date of service, February 26, 2005, CPT code 99232, and the Medicare reimbursement is $54.14 x 125% equals a MAR reimbursement of $67.68. Review of the submitted documentation supports that the insurance carrier issued payment in the amount of $67.68. The requestor is therefore not entitled to additional reimbursement for CPT code 99232.

   Date of service, February 27, 2005, CPT code 99232, and the Medicare reimbursement is $54.14 x 125% equals a MAR reimbursement of $67.68. Review of the submitted documentation supports that the insurance carrier issued payment in the amount of $54.14. The requestor is therefore entitled to an additional payment in the amount of $13.54.

   Date of service, February 28, 2005, CPT code 99239, and the Medicare reimbursement is $93.49 x 125% equals a MAR reimbursement of $116.86. Review of the submitted documentation supports that the insurance carrier issued payment in the amount of $116.86. The requestor is therefore not entitled to additional reimbursement for CPT code 99239.

   Date of service, March 9, 2005, CPT code 99213, and the Medicare reimbursement is $49.51x 125% equals a MAR reimbursement of $61.89. Review of the submitted documentation supports that the insurance carrier issued payment in the amount of $61.89. The requestor is therefore not entitled to additional reimbursement for CPT code 99213.

4. Review of the submitted documentation supports that the requestor is not entitled to additional reimbursement for the disputed charges rendered on February 24, 2005 through March 9, 2005.

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

Authorized Signature

		April 1, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing 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 §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

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