**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**
RYAN NELSON POTTER, MD

**Respondent Name**
MARYLAND INSURANCE COMPANY

**MFDR Tracking Number**
M4-07-1749-01

**Carrier's Austin Representative**
Box Number 19

**MFDR Date Received**
November 10, 2006

## REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "THE CODE 99213 WAS PAID INCORRECTLY. THE EOB WE RECEIVED SHOWED THAT A PAYMENT OF $29.65 WAS PAID FOR THIS CODE. THE CODE SHOULD BE PAID AS FOLLOWS PER RULE 134.202: (MEDICARE ALLOWABLE) $19.30 X 1.25% = $61.63 CARRIER PAID $29.65. CARRIER OWES $31.98."

**Amount in Dispute:** $31.98

## RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "All fees for reasonable and necessary medical treatment were paid according to MFG and evidence based medicine guidelines. Provider has been appropriately reimbursed for all reasonable and necessary medical treatment."

**Response Submitted by:** Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

## SUMMARY OF FINDINGS

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| February 24, 2006 | Professional Medical Services | $31.98 | $31.98 |

## 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 medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the fee guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - C – ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE.
   - 0096 – BYPASS DUPLICATE RULES.

**Issues**

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the maximum allowable reimbursement (MAR) for the services in dispute?

3. Is the requestor entitled to reimbursement?

**Findings**

1. The insurance carrier reduced payment for disputed services with reason code C – "ANY NETWORK REDUCTION IS IN ACCORDANCE WITH THE NETWORK REFERENCED ABOVE." Review of the submitted information found no documentation to support that the disputed services are subject to a contract between the parties to this dispute. Nevertheless, on June 4, 2012, the Division requested the respondent to provide a copy of the referenced contract between insurance carrier and the alleged network, as well as a copy of the contract between the alleged network and the health care provider, pursuant to former 28 Texas Administrative Code §133.307(l), effective January 1, 2003, 27 Texas Register 12282, which states that "The commission may request other additional information from either party to review the medical fee issues in dispute. The other additional information shall be received by the division within 14 days of receipt of this request." As of the date of this review, the respondent has not provided the additional information requested by the Division; therefore, this decision is based on the information available at the time of the review. No documentation was found to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute; therefore, the insurance carrier's reduction reason is not supported. Consequently, the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.202(c), effective January 5, 2003, 27 *Texas Register* 4048 and 12304, which requires that " 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%." Reimbursement is calculated as follows: The Medicare payment amount for procedure code 99213 for 2006 for a provider located in Corpus Christi, Texas, is $ 49.30. This amount multiplied by 125% results in a MAR of $61.63.
3. The total recommended payment for the services in dispute is $61.63. The insurance carrier has paid $29.65, leaving an amount due to the requestor of $31.98. This amount is recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $31.98.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $31.98 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

**Authorized Signature**

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

5/23/14
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.**