



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

VICTORY MEDICAL & FAMILY CARE

Respondent Name

NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number

M4-11-0447-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

OCTOBER 4, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The code 99203 was denied stating 'State regulations do not allow for an office visit and therapy to be done on the same date of service.' The office visit charge was for the physician to examine the patient, take down medical history, justify reasonable treatment and establish a work status. These were all performed by Ralph Hadley, PAC....There is o reason the provider...should not be reimbursed for his initial examination of the patient because the received acute care therapy on the same date of service."

Requestor's Supplemental Position Summary dated November 2, 2010: "The letter provided by Monica Culpepper w/Corvel is incorrect. There are 2 dates of service w/the codes 97110 & 97140."

Amount in Dispute: \$124.06

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The above requestor is correct. It appears that the services in question were denied incorrectly. Corvel has processed the office visit in question for an additional allowance of \$102.17...However, during the process of determining the additional payment due to provider Ralph Hadley, PA an overpayment for the same services performed by another provider on the same date of service was discovered."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 15, 2010	CPT Code 99203-25 New Patient Office Visit	\$124.06	\$124.06

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 §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputes service.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 107-Denied-qualifying svc not paid or identified.
 - R25-Procedure billing restricted/see state regulations.
 - 168-No additional allowance recommended.
 - 25-Separate E&M Service, Same Physician.
 - B13-Payment for service may have been previously paid.

Issues

1. Is the disputed service a duplicate service rendered on July 15, 2010?
2. Is the requestor entitled to reimbursement?

Findings

1. The respondent maintains the denial of reimbursement for CPT code 99203 based upon "the same services performed by another provider on the same date of service was discovered." The respondent did not submit any documentation to support this position.

The requestor contends that payment is due because "There are 2 dates of service w/the codes 97110 & 97140." In support of their position, the requestor submitted invoices for services provided by Ralph Hadley on July 15, 2010, and Lanny Brustein on July 16, 2010.

The Division finds that the requestor supported that services were rendered on two different dates by two different providers; therefore, the disputed service is not a duplicate and reimbursement per the Division fee guidelines is recommended.

2. Per 28 Texas Administrative Code §134.203(c)(1)(2), "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. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of \$50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the \$51.90 (with the exception of surgery) Division conversion factor in 2007."

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

The 2010 DWC conversion factor for this service is 54.32.

The Medicare Conversion Factor is 36.8729

Review of Box 32 on the CMS-1500 the services were rendered in Austin, Texas. Therefore, the Medicare participating amount will be based on the reimbursement for "Austin, Texas".

The Medicare participating amount for CPT code 99203 is \$99.46.

Using the above formula, the MAR is \$146.52. Because the services were provided by a Physician Assistant services are paid at 85% of the MAR for physicians; therefore, \$146.52 X 85% = \$124.54. The requestor is seeking \$124.06; therefore, 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 \$124.06.

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 \$124.06 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

06/13/2014
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.